



A Sourcebook on Medicaid's Role in Early Childhood

Advancing High Performing Medical Homes
and Improving Lifelong Health

Kay Johnson and Charles Bruner, Ph.D.

October 2018



A Sourcebook on Medicaid's Role in Early Childhood

Advancing High Performing Medical Homes and Improving Lifelong Health

Kay Johnson, Johnson Group Consulting, Inc.

Charles Bruner, Ph.D., Co-Principal Investigator for the Health Equity and Young Children Initiative, Child and Family Policy Center

October 2018

Suggested citation: Johnson K & Bruner C. *A Sourcebook on Medicaid's Role in Early Childhood: Advancing High Performing Medical Homes and Improving Lifelong Health*. Child and Family Policy Center, 2018.

Report available at www.cfpciowa.org

Kay Johnson

Over the past 35 years, Kay Johnson has become nationally recognized for her work in maternal and child health policy, as a researcher, advocate, and consultant. Johnson is president of Johnson Group Consulting—a national firm based in Vermont since 1998. Since 1984, she has been active in Medicaid and EPSDT at the federal and state levels and as a consultant advisor to more than 40 states. Her expertise encompasses a range of child and family health issues, including: perinatal and preconception care; home visiting; early childhood development and mental health; immunization; oral health; genetics and newborn screening; adolescent health; and services for children with special needs and disabilities. She previously worked in academia and as health policy senior staff roles in organizations such as the March of Dimes and Children's Defense Fund. Prior to her policy career, Johnson provided direct service to low-income families in early care and education, including child care centers, early intervention programs, and preschool special education/inclusive child care projects in the 1970s. She has written more than 100 policy reports and professional peer-reviewed journal articles and more than 150 keynote and juried speeches. She holds a Master's Degree in Public Health (MPH) from the University of North Carolina, as well as a Master's Degree in Education (MEd) from the State University of New York at Buffalo where she studied child development.

Charles Bruner

Charles Bruner currently serves as a Senior Fellow at the Center for the Study of Social Policy and at the RISE Institute, as well as a FCPA (freelance child policy agitator). In 2016, Bruner retired as Founding Director of the Child and Family Policy Center (CFPC), which he established in 1989 to "link research and policy on issues vital to children and families." Prior to that, he served 12 years in the Iowa General Assembly, the last eight as a state senator. He holds a Ph.D. from Stanford University in political science. Bruner consults with national foundations and state and federal policy makers and advocates to develop more comprehensive and holistic responses to vulnerable children. He is recognized for synthesizing research and using the best available knowledge and information to develop policy through collaborative work across researchers, policy makers, advocates, and children and families with the greatest stake in improving children's opportunities and lives. Bruner's publications include *Clinical Health Care and Community Building* (with Edward Schor), *Early Learning Left Out*, *More Than Health Insurance* (with James Perrin), and *ACE, Place, Race, and Poverty: Building Hope for Young Children*. He received the Florette Angel Memorial award in 2012 from Voices for America's Children for his contributions to the field of child advocacy. The website, www.childequity.org, offers an introduction to his work and thinking.

Preface

Health and well-being over the life span begin before birth and are profoundly affected by events in the early years (0-5) — at home, in health care, and in the community.

This sourcebook describes opportunities under state Medicaid programs to finance more preventive, developmental, and family-centered services for young children. It is designed for use by a broad audience that includes primary care child health practitioners and champions, state Medicaid and child health program staff, child health policy advocates, other health and social service professionals engaged with young children, and state policymakers.

With support from the Robert Wood Johnson Foundation and the Kresge Foundation, the Child and Family Policy Center partnered with the BUILD Initiative in 2015 and 2016 to lead a Learning Collaborative on Health Equity and Young Children. Building on this work with continued funding from the Robert Wood Johnson Foundation, the Child and Family Policy Center led a “Health Equity and Young Children” initiative in 2017 and 2018. The initiative engaged a group of exemplary programs and practices as a collaborative innovation network (CoIN) in deeper discussions around the emerging transformation of primary health care for young children. Based on the CoIN’s insights, the Center developed resources on the core elements in transforming primary and preventive child health practice to respond more effectively to young children and their families (see references in this report and www.cfpciowa.org/en/issues/health_equity/).

The exemplary programs and practices emphasize and illustrate the need to secure sustainable financing, particularly from Medicaid, to advance this work. This sourcebook is a direct result of their experiences in developing and spreading exemplary practices, the challenges of securing financing to do so, and present and emerging ways to use Medicaid to achieve this end.

Kay Johnson and Charles Bruner are the authors of this sourcebook. They view it as a living document for the field. Staff of the Child and Family Policy Center edited and produced the sourcebook. We are grateful to Sara Rosenbaum, Elisabeth Burak, and Jocelyn Guyer, who reviewed an earlier draft and provided valuable comments.

All findings and conclusions are those of the authors and not the funders of this work or the expert advisory panel of the Health Equity and Young Children Initiative.



Charles Bruner

Co-Principal Investigators, Health Equity and Young Children Initiative



Angelica Cardenas-Chaisson

Table of Contents

Preface	3
Executive Summary	7
<i>Organization of Sourcebook</i>	7
<i>Highlights</i>	8
Overview	15
<i>Medicaid as Source of Health Coverage for Children</i>	15
<i>Variation across States in Medicaid Enrollment, Spending, and Utilization among Children</i>	19
<i>References</i>	26
Part One: The Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Benefit for Children	29
<i>Basic EPSDT Framework</i>	30
<i>EPSDT Well-Child Visits</i>	31
<i>Medically Necessary Treatment Services</i>	32
<i>References</i>	35
Part Two: High Performing Medical Homes for Young Children: Covering Well-Child Care to Meet <i>Bright Futures</i> Guidelines	37
<i>Defining and Financing a High Performing Medical Home</i>	40
<i>Aiming for Quality in Well-Child Visits</i>	42
<i>References</i>	45
Part Three: High Performing Medical Homes: Care Coordination and Case Management	47
<i>Defining Care Coordination and Case Management</i>	48
<i>Case Management and Care Coordination in Medicaid</i>	50
<i>Beyond Basic Care Coordination: Key Attributes of Effective Practice</i>	51
<i>Approaches to Financing for Care Coordination</i>	54
<i>Identifying Child and Family Need for Care Coordination and Complexity of Needed Response</i>	54
<i>Measuring the Impact of Care Coordination</i>	55
<i>References</i>	56
Part Four: Screening in High Performing Medical Homes: Development, Health, and Well-being	59
<i>Screening as a Core Part of a High Performing Medical Home</i>	60
<i>Addressing the Roots of Health and Well-being in a High Performing Medical Home</i>	61
<i>Developmental Screening and EPSDT</i>	62
<i>Screening for Social Determinants of Health</i>	66
<i>References</i>	68

Part Five: Medicaid Financing for Other Needed Services Promote Healthy Child Development Within and Beyond the Medical Home	71
<i>Augmenting Primary Health Care to Address Bio-medical and Social Determinants of Health</i>	72
<i>Augmenting Primary Health Care Office Responses by Incorporating Additional Services</i>	73
<i>Medicaid Financing in Partnership with through Other State and Federal Programs</i>	77
<i>Medicaid Financing to Support Effective Parenting</i>	83
<i>References</i>	84
Part Six: Optimizing Payment Approaches to Support and Sustain High Performing Medical Homes	87
<i>Financing Approaches to Support Practice Transformation</i>	88
<i>Financing Through Managed Care and Accountable Care Organizations</i>	89
<i>Select Approaches to Promote High Performing Medical Homes for Young Children</i>	90
<i>Value-Based and Performance-Based Purchasing for Children</i>	92
<i>Medicaid Contract Language to Ensure Coverage under EPSDT</i>	93
<i>Medicaid Administrative Claiming</i>	95
<i>References</i>	97
Part Seven: Measuring Performance and Progress Toward High Performing Medical Homes and Better Outcomes	99
<i>Measuring EPSDT Program Performance (416 Data)</i>	100
<i>Measuring Quality in Medicaid and CHIP</i>	103
<i>Measuring Quality & Performance of Pediatric Medical Homes for Young Children in Medicaid</i>	105
<i>Measurement to Promote Shared Accountability</i>	105
<i>References</i>	107
Appendices	109
<i>Appendix A. Medicaid Enrollment and Spending Data by State</i>	111
<i>Appendix B. State EPSDT Periodicity Schedules for Young Children, By State (2016)</i>	117
<i>Appendix C. Opportunities to Improve Effectiveness of Medicaid Investments in Early Childhood</i>	119
<i>Appendix D. Health Equity and Young Children Exemplary Programs and Practices</i>	125
<i>Appendix E. Reimbursing for Office Visits and Screening</i>	131

Executive Summary

Organization of Sourcebook

This sourcebook is designed to support advancements in primary child health care for young children that are preventive, developmental, and responsive to the needs of young children and their families. It reflects work on the cutting edge of such practice and financing reform. The health care system and health care finance are complex, and the different parts of this sourcebook go into depth on different important topics. They all are based on a common framework related to the emerging role of the primary care child health practitioner. This starts with — but often goes beyond — what the practitioner does.

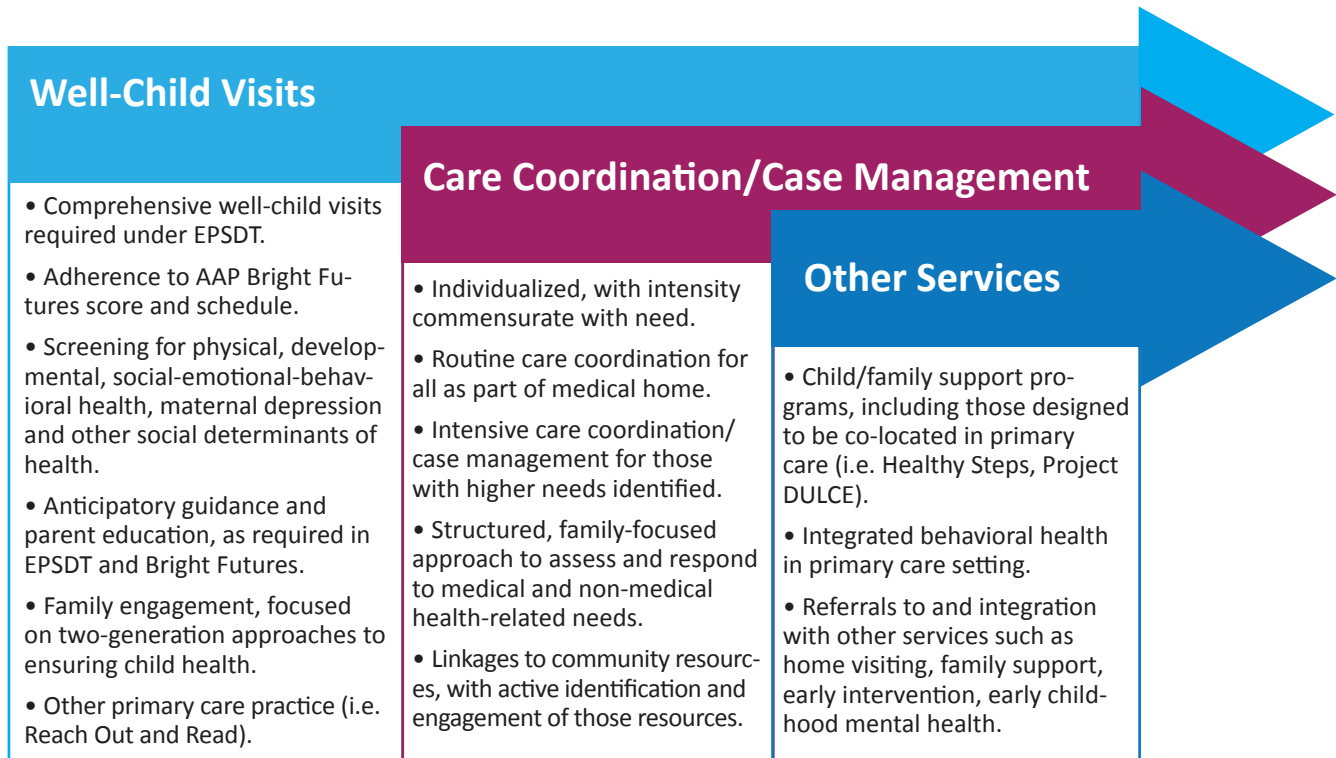
We define this emerging form of practice as a “high performing medical home.” The sourcebook goes into detail on the core elements of a high performing medical home, distinguishing it from common practice today, which is much more limited in its scope and impact. This expanded approach is particularly important for the vulnerable, low-income children covered by Medicaid.

Incorporating these elements into practice involves implementing practice changes and enhancements, establishing a financing system to sustain them, and creating monitoring and measurement systems to ensure their implementation (shown in the table and figure below).

Table: Supporting a High Performing Medical Home for Young Children

	Well-Child Visits and Primary-Care Practice	Care Coordination/Case Management	Other Needed Services
Practice design	Comprehensive EPSDT well-child visits adhering to AAP <i>Bright Futures</i> scope and schedule with appropriate screening, response, and family engagement.	Care coordination/case management ranging from basic care coordination in medical home to more intensive care coordination. Family-focused need assessment and responses to connect to practice and community resources that address need and promote family agency.	Effective completed referrals to in-house or linked services that address both social and bio-medical conditions affecting child health trajectories, including physical, mental, oral, developmental, and social risk factors.
Medicaid financing	Reimbursement to cover costs and incentivize performance, including visits, array of screening, and office administration.	Reimbursement to cover costs — ranging from basic care coordination in medical home to more intensive care coordination — to improve access to timely support for families with identified needs.	Financing additional preventive and developmental health-related services (e.g., home visiting, early childhood mental health, and other program models).
Measurement	Measures and methods to monitor performance and promote quality improvement, building on Medicaid/CHIP Child Core Measures set.	Measures and methods (e.g., charting and documentation) to monitor performance and promote quality improvement in various types and levels of care coordination.	Measures and methods to monitor performance, demonstrate adherence to effective practices, document connections to improving child health, and promote shared accountability.

Figure: Design for High Performing Medical Homes in Medicaid



Medicaid provides health coverage for millions of low-income Americans, including children, persons with disabilities, adults 19-64, and seniors >65. It is a primary source of coverage for children. Combined with the Children's Health Insurance Program (CHIP), Medicaid provided coverage for 46 million children, out of a total population of 78 million children, at least some time during federal fiscal year (FFY) 2016. Expansions to Medicaid and the establishment and expansion of CHIP reduced the percentage of uninsured U.S. children from 17 percent in 1990 to less than 5 percent in 2016.

Medicaid is particularly important as a source of coverage for the youngest children. U.S. Census data indicate that Medicaid covered just over 40 percent of young children (0 to 5) in 2016. State-reported data show that 60 percent of children 0 to 3 and 56 percent of children 3 to 5 were enrolled in Medicaid during FFY 2016.

Medicaid is a federal-state partnership in terms of its funding and structure. Federal law establishes certain minimum eligibility, benefit, and other requirements, while states play the central role in implementing Medicaid, including establishing eligibility above federal minimums, provider reimbursement rates, and use of managed care arrangements.

State-level information on Medicaid's coverage and financing for child health services points to areas of need and opportunity. There is wide variation in state implementation, but all states are in a position to improve their Medicaid systems as they relate to providing more preventive, developmental, and family-centered responses for young children. Variations among states include:

- *Eligibility Levels for Children in Medicaid*
On average nationally, as of January 2018, child eligibility levels were 195 percent of poverty for infants and 164 percent of poverty for children ages 1-5, but eligibility levels vary substantially by state.
- *Proportion of All Children Covered under Medicaid and CHIP*
While Medicaid and CHIP together cover 59 percent of all U.S. children under age 18, the proportion varies across states, from a low of 32 percent to a high of 80 percent. Such variations reflect different child poverty rates, Medicaid/CHIP eligibility levels, and efforts to enroll children.
- *Proportion of Children with No Health Insurance Coverage*
Because of Medicaid expansions and CHIP, all states have increased health coverage levels among children, but the gains are uneven. Across the states, the percentage of uninsured children ranges from a low of 0.9 percent in Massachusetts to a high of 9.2 percent in Texas.
- *Proportion of Medicaid Beneficiaries who are Children*
Nationally, children made up 43 percent of enrollees in Medicaid in FFY 2014. Again, there were wide variations among states, primarily driven by: 1) the percentage of low-income children in the state; 2) the levels of eligibility for children; and 3) the substantial variations in eligibility and coverage levels for adults 19-64 (including whether it has expanded Medicaid under the Affordable Care Act).
- *Medicaid Expenditures for Children as Proportion of All Medicaid Expenditures*
Due to lower health care costs and Medicaid expenditures, children account for a disproportionately smaller share of spending than other Medicaid enrollees. Nationally, children counted for only 19 percent of Medicaid expenditures in FFY 2014, with children's share of expenditures below the national average in many states. Similar to the variations in children as a proportion of enrollees, the eligibility levels for adults and the number of poor children both affect the percent of spending by eligibility group.
- *Medicaid Expenditures per Enrolled Child*
States may finance more or fewer services for children in Medicaid and provide greater or lesser reimbursements. Nationally, the average expenditure per enrolled child overall was \$2,527 in FFY 2014. Six states had per-child expenditures below \$2,000 and five states had expenditures more than twice that amount. These differences cannot be explained by variations across states in child health status; they relate to state Medicaid program decisions.
- *Utilization of Preventive Well-Child EPSDT Visits*
Medicaid data submitted by states provide information on preventive well-child visits by age. There is a national performance standard that 80 percent of 1- and 2-year-olds have at least one well-child visit, but only 20 states met this minimum standard in FFY 2016. The Medicaid/CHIP primary core measure for well-child visits in this age group is the percentage of children receiving six or more visits by 15 months; states' performances ranged from 29 percent to 83 percent in FFY 2016.

Highlights from Part One

The Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Benefit for Children

- EPSDT is the child health benefit in Medicaid. It sets federal requirements and expectations for using Medicaid to promote and improve child health. Required in every state Medicaid program, EPSDT finances a wide array of appropriate and necessary pediatric services. The EPSDT benefit provides a legal entitlement to children covered under Medicaid and is intended to guarantee children coverage for all services allowed under Medicaid in federal law, even if the state does not cover them for other populations.
- EPSDT requires states to finance a wide array of prevention and treatment services. This includes comprehensive well-child visits to screen for, identify, and respond early to conditions that affect the child's health. EPSDT required benefits also include informing families about their benefits, providing assistance in scheduling appointments, arranging for treatment, and financing transportation to keep appointments.
- Despite federal requirements, states vary in how they implement the EPSDT benefit, both in terms of preventive and primary care and services for children with special health care needs (CSHCN), disabilities, and other conditions necessitating treatment.
- Medicaid and its EPSDT benefit not only enable but set expectations for states to provide high-quality primary and preventive health care. Federal law sets a strong framework and expectation for states to provide comprehensive preventive services for young children, starting with the office visit. EPSDT forms a legal basis for financing high performing medical homes for young children and other prevention and early intervention services.

Highlights from Part Two

High Performing Medical Homes for Young Children: Covering Well-Child Care to Meet *Bright Futures* Guidelines

- Child health practice is undergoing a transformation, broadening its focus from treating disease and managing existing health conditions to promoting healthy development. Children's primary care providers are expanding their role in responding to social as well as bio-medical determinants of health. Science and expert recommendations guide such shifts, which are particularly important in the earliest years of life. *Bright Futures* guidelines describe this role and a patient/family-centered medical home, defining expanded relationships with children, their families, and other community services.
- A growing base of exemplary primary care practices demonstrate the feasibility and value of providing such care for young children, called here "high performing medical homes" to distinguish them from the current general standard of care. While current general primary child health practice provides value in identifying medical concerns, providing immunizations, and treating illnesses and injuries, this practice falls short for the one-quarter to one-third of young children for whom social determinants jeopardize healthy development and who are at very early stages of compromised development. High performing medical homes move beyond this current general practice and have much more value in promoting healthy development, but require more time and resources to achieve optimal outcomes.

- Moving from isolated exemplary practices to widespread diffusion requires Medicaid financing that supports and sustains best practices, including comprehensive well-child visits and the additional care coordination, practice enhancements, and linkages to community services needed to address children’s healthy development.
- To do so, states need to differentiate between general pediatric practice and that provided by high performing medical homes. Medicaid reimbursement rates and incentives (either directly or through managed care contracts) should be set accordingly. This includes reimbursements for the well-child visit itself and other office practices (including screening, discussed in part four). States need to use quality measures to monitor high performing medical homes to assure they provide the expected level of care.

Highlights from Part Three

High Performing Medical Homes: Care Coordination and Case Management

- The terms “care coordination” and “case management” are both used, often interchangeably, to describe a range of activities that better link children and families to services and supports, promote access, ensure follow up and address needs. A basic level of care coordination/case management for all patients is a defined part of the medical home.
- While the definition of a medical home includes basic, routine care coordination, some children and their families need more intensive care coordination. When a child has an identified physical, developmental, mental, or other condition, more than basic care coordination/case management may be needed. Similarly, when the child is in a family experiencing social risks and conditions (e.g. social determinants of health) that threaten the child’s health and development, more intensive care coordination may be essential. A high performing medical home in Medicaid must provide care coordination capable of responding to both bio-medical and social risks and conditions.
- Under EPSDT, children are entitled to case management coverage. Medicaid regulations specify a case management benefit, but do not define “care coordination.” States also can use the targeted case management (TCM) benefit under Medicaid, with flexibility to offer certain services to individuals in defined groups (such as young children), specific geographic areas, and delivered by qualified providers. Federal regulations define the following four categories of activity: 1) assessment, 2) development, 3) referrals and relative activities, and 4) monitoring and follow-up. In addition, states can pay for an array of care coordination activities in primary care settings or in the community apart from the case management benefit.
- Medicaid case management benefit categories can be used to cover this more intensive care coordination. Many states are financing care coordination under the case management or targeted case management benefit categories. Operationally, financing may be through direct reimbursement on a fee-for-services basis, on a capitated basis (e.g., per member, per month-PMPM payment), or through incentives or bonuses for performance. Whatever the finance mechanisms, the costs of both direct time with the child and family and indirect time — to gather information, develop or update the care plan, follow up with families, schedule appointments for referrals, check in with families and monitor the care plan — need to be reflected in the payments.

Highlights from Part Four

Screening in High Performing Medical Homes: Development, Health, and Well-being

- Practice in the high performing medical home should include but go beyond traditional screening for general development in young children to include separate screening for social determinants of health. This is essential for identifying and responding to social determinants of health and related early childhood risks, with emphasis on affecting health trajectories over the life course, not just immediate health conditions.
- Medicaid's EPSDT benefit requires developmental screening. *Bright Futures* guidelines recommend that developmental screening tests for young children be administered during the well-child visits at 9, 18, and 30 months. These visits are reflected in the American Academy of Pediatrics (AAP) periodicity schedule for preventive well-child visits and in some, but not all, state EPSDT schedules. States have opportunities to improve the financing of these services, as well as the use of validated screening tools and measurement of practice, health plan, and state-level performance.
- One measure in the Medicaid/CHIP Child Core Measurement Set is "Developmental Screening in the First Three Years of Life." This measure can be used to monitor how Medicaid providers, managed care plans, and state programs are performing in terms of developmental screening of young children. Not all states have yet adopted this measure.
- Screening for social-emotional development is increasingly used in pediatric primary care for young children. Screening for social-emotional, behavioral, and mental health is part of the EPSDT benefit. Increasingly, providers are offering and Medicaid is financing social-emotional-behavioral screening designed specifically for young children, and some also are conducting maternal depression screening (one core social determinant of health for young children) as part of well-child visits.
- Screening for social-determinants of health is an emerging area, with new tools, practice approaches, and financing opportunities. Responding to SDOH risks and needs identified through screening requires discussions between health providers and families, as well as referrals and follow up.
- As with the reimbursement for well-child visits and care coordination, the level of reimbursement for screenings should reflect the costs of that screening and its use in the practice.

Highlights from Part Five

Medicaid Financing for Other Needed Services

- Many pediatric primary care practices are augmenting their services or increasing linkages with other community providers to better address risks and concerns related to child development, emotional-behavioral factors, or social determinants of health. Evidence-based models to augment primary care — such as Healthy Steps and Project DULCE — are being used in practices across the nation.
- Promoting social-emotional health and well-being, beginning in early childhood, is a nationwide priority. Medicaid is financing an array of preventive and therapeutic services for young children, including ones where the services are directed to ameliorating parent risks that affect child health.

- The social-emotional, mental, and behavioral health of young children is a core foundation for healthy growth and development and is strongly associated with school readiness, achievement, and lifelong health and well-being. EPSDT includes preventive, diagnostic, and treatment services related to mental health and physical health equally. Integrating mental/behavioral health services into primary care is another trend, for both children and adults. Early childhood mental health clinicians offer the opportunity to intervene more effectively in the earliest years of life; effective approaches recognize social and emotional concerns at much younger ages than those for traditional mental health diagnoses.
- Medicaid plays a role in financing home visiting and early intervention services. Dedicated federal funding through the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program and the IDEA Part C Early Intervention Program provides a foundation and infrastructure for needed services but themselves have insufficient funding to cover all children in need. Many states are using Medicaid to finance some of the cost for delivery of these services, particularly when related to improving child health outcomes, which falls within the scope of Medicaid and its EPSDT benefit. Although federal funds cannot be used as a match for Medicaid, state or local funds directed to these programs can.
- Medicaid also provides opportunities for financing other services related to parenting training, education, and group interventions that respond to developmental, social, and emotional risks. This generally requires that primary child health practitioners or other medical clinicians provide authorization for such services, that staff are appropriately credentialed to provide the services, and that the goals for and documentation of the services are clearly enumerated and are based on the child's identified health needs.

Highlights from Part Six

Optimizing Payment Approaches to Support and Sustain High Performing Medical Homes

- Medicaid can and should play a lead role in advancing high performing medical homes for young children. Payment approaches should cover the costs of needed services, incentivize high performance, ensure that services meet standards of care, and result in improving outcomes for the low-income young children served. This can be done under both direct, fee-for-service payment systems or under managed care arrangements.
- In fee-for-service environments, a key step is to establish Medicaid reimbursement levels sufficient to finance and incentivize high performing pediatric medical homes. Appropriate billing codes, service definitions, provider qualifications, and measurement are needed.
- For Medicaid provided through managed care arrangements, states must incorporate into contracts with managed care organizations (MCOs) and accountable care organizations (ACOs) specific expectations and requirements for the finance and delivery of high performing medical homes for young children and other services in line with the EPSDT benefit. This requires distinguishing services for young children from other populations and services in the Medicaid contract and establishing payment structures and distinct performance incentives. In particular, contracts and payment mechanisms should emphasize the preventive and developmental services needed to improve the health and well-being of young children in Medicaid in both the short and long term.

- Three specific payment approaches common to managed care contracts — per member per month payments, pay-for-performance, and use of “shared savings” — also can be used to advance the development of high performing pediatric homes, but they are not a substitute for the other actions described above.
- Medicaid administrative claiming can be used to cover administrative activities needed to maximize the effectiveness and efficiency of high performing medical homes. State Title V Maternal and Child Health Block Grant programs often are in the position to provide or contract for administrative services related to Medicaid (e.g., related provider training, system coordination, measurement) and bill for administrative costs.

Highlights from Part Seven

Measuring Performance and Progress toward High Performing Medical Homes and Better Outcomes

States are responsible for reporting on EPSDT program performance, particularly for medical and dental preventive visits. Most states have not reached the 80 percent performance goal for all children or for young children. States have opportunities to improve EPSDT performance and the quality of data used to monitor performance.

The CMS has defined a core child set of measures for Medicaid and CHIP that are focused primarily on monitoring quality using key indicators of the care process. Many states do not yet report on all of the measures. In 2018, 11 of the 26 measures relate to young children (prenatal to age 5). Individual state performance ranges from 29 to 83 percent in terms of well-child visits in the first 15 months of life.

This sourcebook suggests a set of measures specifically designed to monitor high performing medical homes for young children. These can be used under fee-for-service, managed care, or other financing arrangements for identifying and incentivizing such performance. The measures build on the CMS child core set, with additional measures that relate specifically to the performance of medical homes for children in Medicaid and CHIP.

States have an opportunity to advance measure alignment and shared accountability across health and related programs. For example, creating a common, shared set of early childhood measures across Medicaid, Medicaid managed care, Title V MCH Block Grant, and federal home visiting programs might help drive program performance and practice quality improvement, as well as improved outcomes, for young children and their families.

States also need to have monitoring approaches that go beyond examining a core set of measures collected for all enrollees and encounters to more detailed reviews of a representative sample of cases (e.g. chart reviews) that determine, in particular, that services receiving reimbursement are meeting the standards set for them as high performing medical homes.

Overview

Key Takeaway Messages

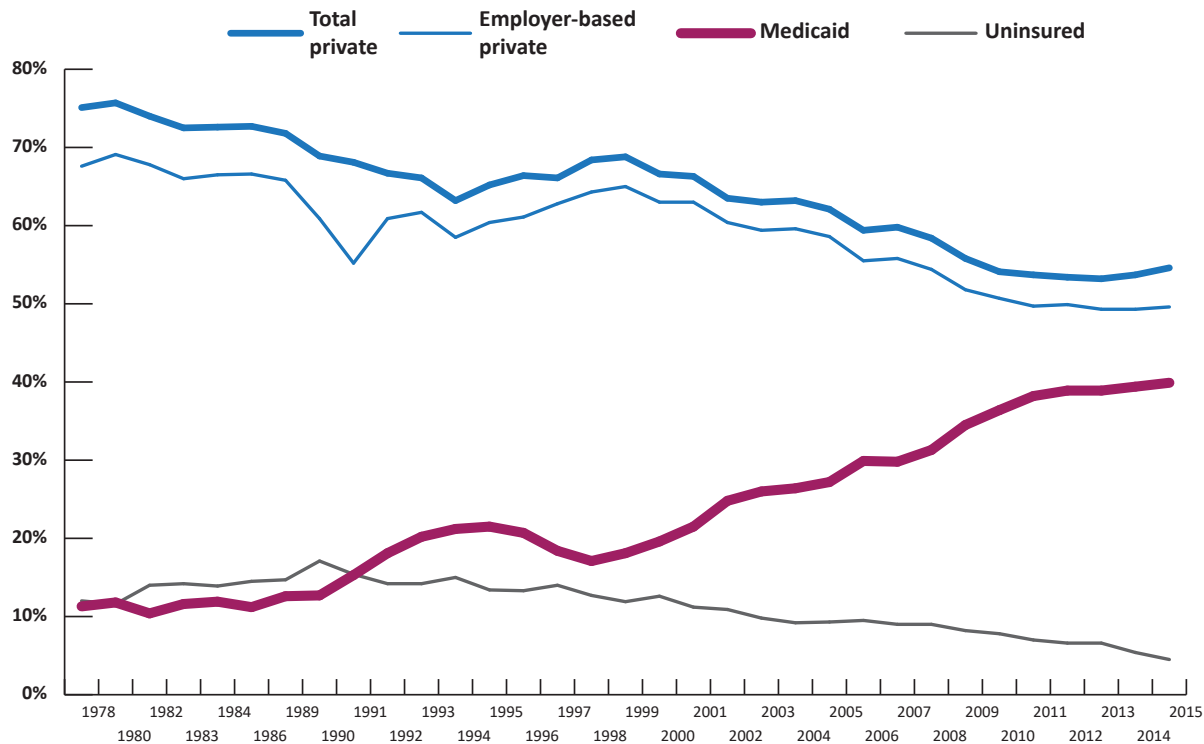
- Medicaid provides health coverage for millions of low-income Americans. It is a particularly important source of coverage for children. Today, an estimated 95 percent of children have health coverage. Combined with the Children's Health Insurance Program (CHIP), Medicaid provides coverage for more than half of all young children (0-5). In Federal Fiscal Year (FFY) 2016, 46 million children were covered under Medicaid/CHIP, out of a total population of 78 million children under age 18. That represents 59 percent of all U.S. children.
- Medicaid is a federal-state partnership in terms of its funding and structure. The federal government provides the majority of funding for Medicaid. Federal law establishes certain minimum eligibility, benefit, and other requirements, while states play the central role in implementing Medicaid, including setting eligibility above federal minimum, provider reimbursement rates, and use of managed care arrangements. While the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit requires children receive recommended preventive well-child visits and treatment services when medically necessary, the benefit is not uniformly implemented across states. (See part one for details about the EPSDT benefit.)
- Even though Medicaid and CHIP cover a majority of all U.S. children under age 18, program performance for children varies widely by state. Differences in the reach, scale, and performance of Medicaid result from state flexibility in implementing the program. This includes variations in the percentage of children covered, the percentage of Medicaid enrollment and spending accounted for by children, per-child spending, and how many children receive preventive or other services. All states have opportunities and flexibility to use Medicaid to better finance health and related services for young children.

Medicaid as a Source of Health Coverage for Children

The share of children with health insurance has risen substantially thanks to increases in publicly supported coverage, beginning in 1984 with a series of Medicaid eligibility expansions and enactment of the Children's Health Insurance Program (CHIP) in 1997.^{1 2 3} Those gains occurred with increases in coverage provided by Medicaid and CHIP, despite increases in the costs of family and dependent coverage under employer-based health plans and individually purchased plans (and decline in the proportion of children covered under those private plans). The uninsured rate for children has been nearly cut in half since 2009.⁴ By 2016, 95 percent of children had health coverage, and Medicaid/CHIP participation reached 94 percent among eligible children.⁵ Many children who are not covered today are eligible for Medicaid or CHIP but have not enrolled; others are not eligible due to their residency status (states can select, but are not required, to cover legal residents who are not yet citizens. Undocumented children are not federally eligible for either Medicaid or CHIP).

Figure 2 shows national data on the decline in the percentage of uninsured children. Similar charts can be constructed for any state, and virtually all states have shown improvements in child health coverage rates over this period. (The most recent data indicate progress may have slowed between 2015 and 2017.⁶)

Figure 2. Health Coverage among Children under Age 18 by Type of Coverage, U.S., 1978-2015



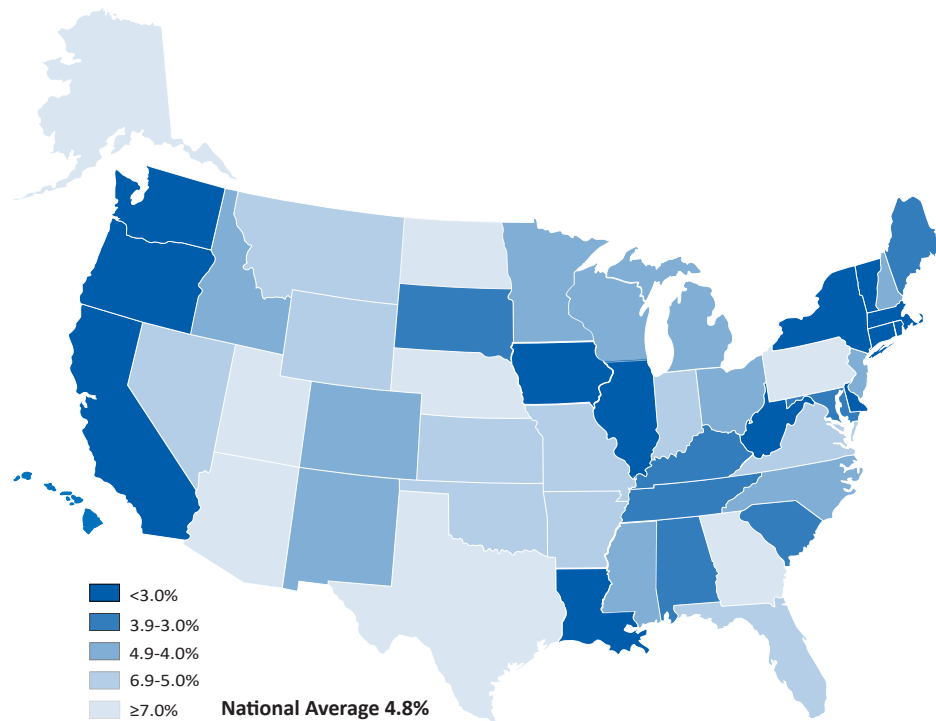
Source: Health, United States, 2016. <http://www.cdc.gov/nchs/hus/contents2016.htm#fig26> National Health Interview Survey, National Center for Health Statistics, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services.

Progress has not been even across the country. The percentage of uninsured children ranges from a low of 0.9 percent in Massachusetts to a high of 9.2 percent in Texas (Figure 3).⁷ Currently, while the vast majority of children now have health insurance coverage of some type, some states have substantially more work to do to get children covered. Some states with high proportions of children covered by Medicaid also have relatively high rates of uninsured children, because they have much larger proportions of children who are poor and without private coverage.

As a result of the federal-state policy decisions and coverage trends, Medicaid and CHIP have become a critical source of financing — often the single largest payer — for young children’s health services. There are different Medicaid estimates for the percentage of children covered under Medicaid, but all show a substantial share of the young child population covered. U.S. Census data (based on reports of the adults/parents completing the survey, which tend to underrepresent coverage) show that just over 40 percent of young children (0-5) were covered by Medicaid in 2016.⁸ State data reported to the Centers for Medicare and Medicaid Services (CMS) show that 60 percent of children 0 to 3 and 56 percent of children 3 to 5 — 13.8 million young children total — were enrolled in Medicaid some time during FFY2016. The authors of this report believe that more than half of all young children are covered under Medicaid and CHIP for a portion of any given year, and that this figure is higher for children with special health care needs.

This means that Medicaid plays a dominant role in financing the preventive, developmental, socio-emotional, and other services needed to support optimal health in the early years. Young children are the age group most likely to live in poverty (20 to 25 percent are poor) and poverty has strong associations with virtually all measured child outcomes (physical, educational, and social), extending to adolescent

Figure 3. Percentage of Low-income Young Children Who Were Uninsured, By State, 2016



Source: Georgetown University Center for Children and Families tabulations of the 2016 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS).

parenting, justice system involvement, employment, and family formation as young adults. Ensuring that low-income young children receive the services they need to get a strong start and avoid a lifetime of adverse health and other consequences is a key role for Medicaid.

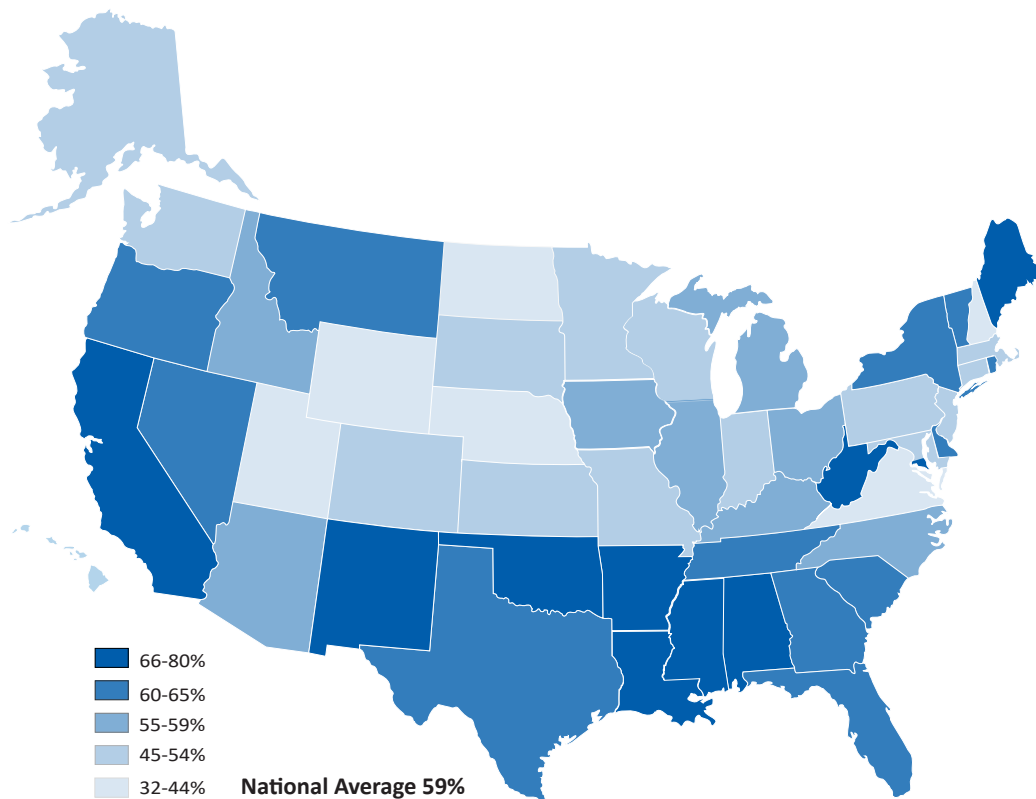
Medicaid is a federal-state partnership in funding and structure. Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit sets the parameters for comprehensive health coverage for children. Federal law requires child health coverage that is preventive, developmental, and more comprehensive than coverage for adults (see parts one and two).

While federal law frames the requirements for children's benefits and the federal government provides the majority of funding for Medicaid, states play the central role in implementing Medicaid. Specifically, states do the following and more:

1. Establish eligibility levels for Medicaid, at or above federal minimum requirements;
2. Determine what optional services will be provided (federal law has a set of mandatory and optional services), and rules around their use (eligibility for, scope and duration of services);

Medicaid and CHIP have become a critical source of financing — often the single largest payer — for young children's health services. This means Medicaid plays a dominant role in financing the preventive, developmental, socio-emotional, and other services needed to support optimal health in the early years.

Figure 4. Percentage of All Children under Age 18 Covered by Medicaid and/or CHIP at Any Time during Year, By State, FFY2016



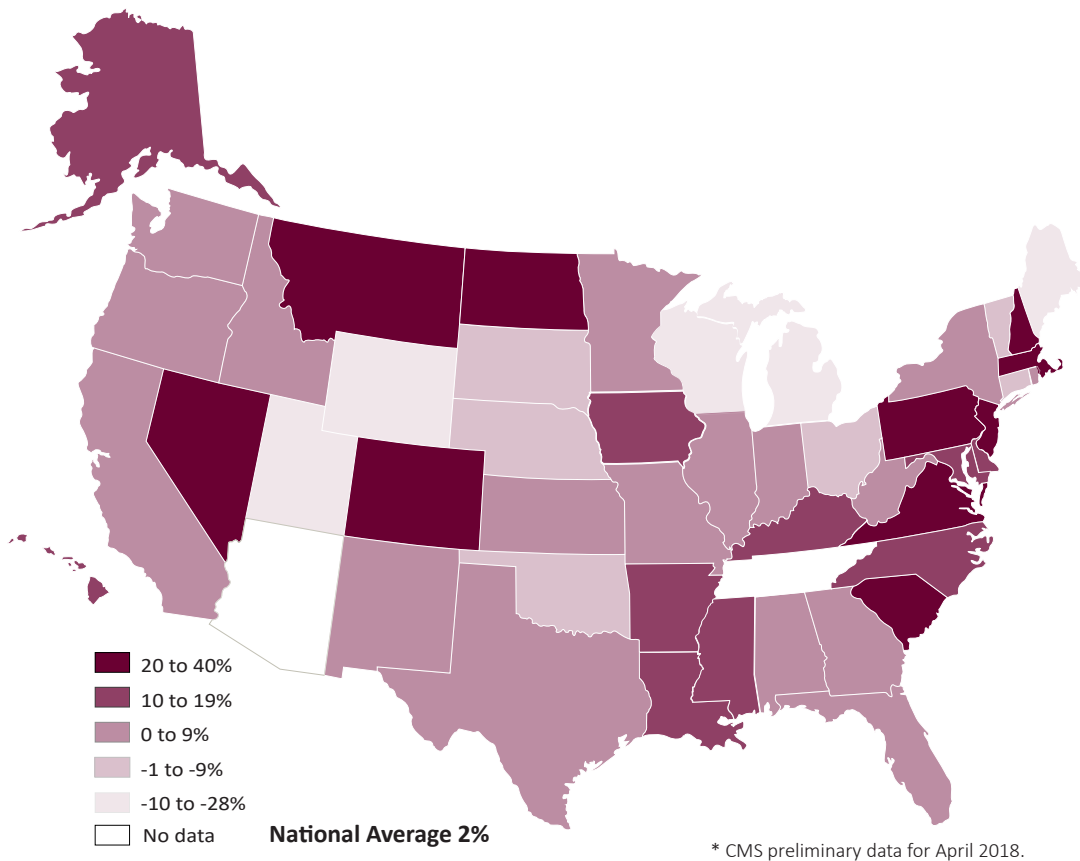
Source: MACPAC, based on CMS data for FFY2016.

3. Set provider reimbursement rates;
4. Define provider qualifications; and
5. Enroll providers directly to provide Medicaid financed services and/or contract with managed care and other entities to do so to organize provider networks.

As with Medicaid, CHIP is funded jointly by states and the federal government and is administered by states, according to broad federal requirements. CHIP provides coverage either through purchase of private insurance coverage or coverage under Medicaid. Children enrolled in CHIP Medicaid expansion qualify for Medicaid benefits.⁹

Medicaid/CHIP coverage matters in large part because it improves children's access to health services and can improve their health outcomes. Decades of studies have led to two important findings: 1) when Medicaid provides adequate coverage, children generally have access to care similar to their privately insured counterparts; and 2) Medicaid can leverage the quality, effectiveness, and outcomes of health and related services for enrolled children. Using data from the National Health Interview Survey (NHIS) to assess changes in Medicaid and CHIP coverage for children between 2008 and 2015, the Urban Institute found that among children covered by Medicaid and CHIP: 1) a smaller proportion of children did not receive needed care because their families could not afford it; 2) more children had a usual source of care; and 3) fewer children had difficulty finding a physician to serve them.¹⁰

Figure 5. Percent Change in Medicaid/CHIP Child Enrollment, FFY2014 to April 2018



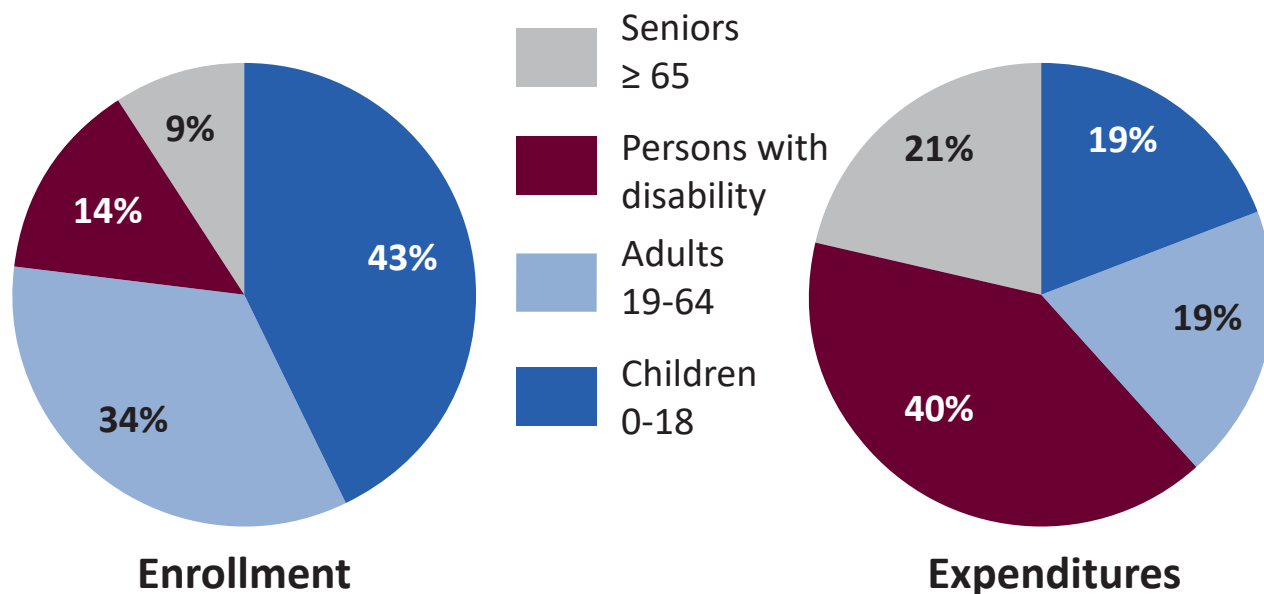
Source: CMS Data 2014 and CMS Preliminary Data April 2018.

Variation across States in Medicaid Enrollment, Spending, and Utilization among Children

While Medicaid and CHIP cover a majority of all U.S. children under age 18, program performance for children varies widely by state. There is no single source of information on Medicaid and CHIP, and various data sources highlight differences by state in eligibility, enrollment, spending, and service utilization. This section of the sourcebook illustrates and discusses such variations in state policy and performance. (See Appendix A for data tables.)

State-by-state Medicaid data on children have some limitations. First, some children — an estimated 1.6 million¹¹ — are covered under the Medicaid disability category rather than the child eligibility category, typically but not exclusively those enrolled via the Supplemental Security Income (SSI) program for persons with disabilities. Second, some states use Medicaid/CHIP approaches, while other states use a separate CHIP program or a combination. Third, states may report on different age ranges of children (e.g., up to 18th or the 21st birthday). Fourth, some data sources report on the children ever covered by Medicaid during the course of an entire year, while others look at coverage at a specific point in time. Estimates of the percentage of births that are financed by Medicaid are based on different state methods, such as using claims data or linking to vital statistics (Medicaid birth data are not shown here). Finally, understanding children's coverage requires knowing how states cover other eligible populations of individuals over age 18.

Figure 6. Medicaid Enrollment and Spending, U.S. Average Percentage, FFY 2014



Source: Kaiser Family Foundation. Based on reports from states to the U.S. HHS Centers for Medicare and Medicaid Services.

Eligibility Levels for Children in Medicaid

On average nationally, as of January 2018, child eligibility levels were 195 percent of poverty for infants, 164 percent of poverty for young children ages 1-5 years, and 142 percent of poverty for children ages 6-18 years.^{12 13} Comparisons across states point to variations, with some covering infants and young children with family income at or above 300 percent of the federal poverty level. Notably, federal law requires states to have mechanisms in place to automatically enroll a newborn if the birth was financed by Medicaid and to provide continuous eligibility throughout the first year of life. States have the option to provide continuous annual enrollment periods for children ages 1-21 years.

Proportion of All Children Covered Under Medicaid and CHIP

For the United States as a whole, in Federal Fiscal Year (FFY) 2016, 46 million children under age 18, out of a total population of 78 million children, were covered under Medicaid and CHIP combined at least sometime during the year (see Appendix A for data table and sources.) Of the total, 37 million children were covered under Medicaid and 9 million enrolled in CHIP. Together, Medicaid and CHIP cover 59 percent of all children under age 18. As shown in Figure 4, the proportion of children covered by Medicaid/CHIP varies across states, from a low of 32 percent to a high of 80 percent. As discussed further below, this reflects both child poverty rates and Medicaid/CHIP eligibility levels. Nationally, young children are more likely to be covered as a result of Medicaid eligibility levels and a higher proportion of young children living in poverty.

As portions of the ACA were implemented starting in 2010, more children enrolled in Medicaid and CHIP. Generally, this is not due to expansion of children's eligibility levels but to more families seeking advice about publicly subsidized health coverage, more parents becoming eligible for Medicaid coverage in expansion states, and having both parents and children enroll in Medicaid, CHIP, or ACA exchange marketplace plans. The effects were largest among children whose parents gained Medicaid eligibility un-

der the ACA expansion to adults. Researchers estimate that if all states had adopted Medicaid expansion, an additional 200,000 low-income children would have gained coverage.¹⁴ Figure 5 shows the percent change in Medicaid/CHIP child enrollment by state, comparing FFY 2014 to preliminary enrollment estimates for April 2018. Other studies have found that for young children, the effects of Medicaid expansions for parents were particularly important.¹⁵

Proportion of Medicaid Beneficiaries that are Children

Medicaid covers several categories of low-income people, including children, persons with disabilities, seniors age 65* and over, and adults ages 19-64. (Note that children may be counted in the disability category and are sometimes counted to age 18 and other times to age 21.) Nationally, in recent years, children have made up approximately 40 percent of enrollees in Medicaid. (See Figure 6.) With 34 states adopting the Medicaid expansion option under the ACA between 2010 and 2018, millions of low-income adults under age 64 have enrolled in Medicaid. As a result, the proportion of beneficiaries who are children has declined somewhat in recent years. Still, children are the largest single enrollment group covered by Medicaid, and the percentage is even higher when Medicaid and CHIP are combined.

Children are the largest single enrollment group covered by Medicaid, and the percentage is even higher when Medicaid and CHIP are combined.

Proportion of Medicaid Beneficiaries that are Children

Figure 7 shows variations in the percentage of Medicaid /CHIP enrollees who are children. This map is often used to show comparisons across state Medicaid programs on who is covered. Just because a state has a high percentage, however, does not mean that it has a high rate of covering children. These commonly used data must be interpreted with a lot of caveats. State-to-state variations are primarily driven by: 1) the coverage levels for adults 19-64, including whether the state has expanded Medicaid under the ACA; 2) the percentage of low-income children in the state; and 3) the eligibility levels set for children. While the level of child poverty contributes to the percent of enrollees that are children, state decisions on adult coverage have a much stronger effect.

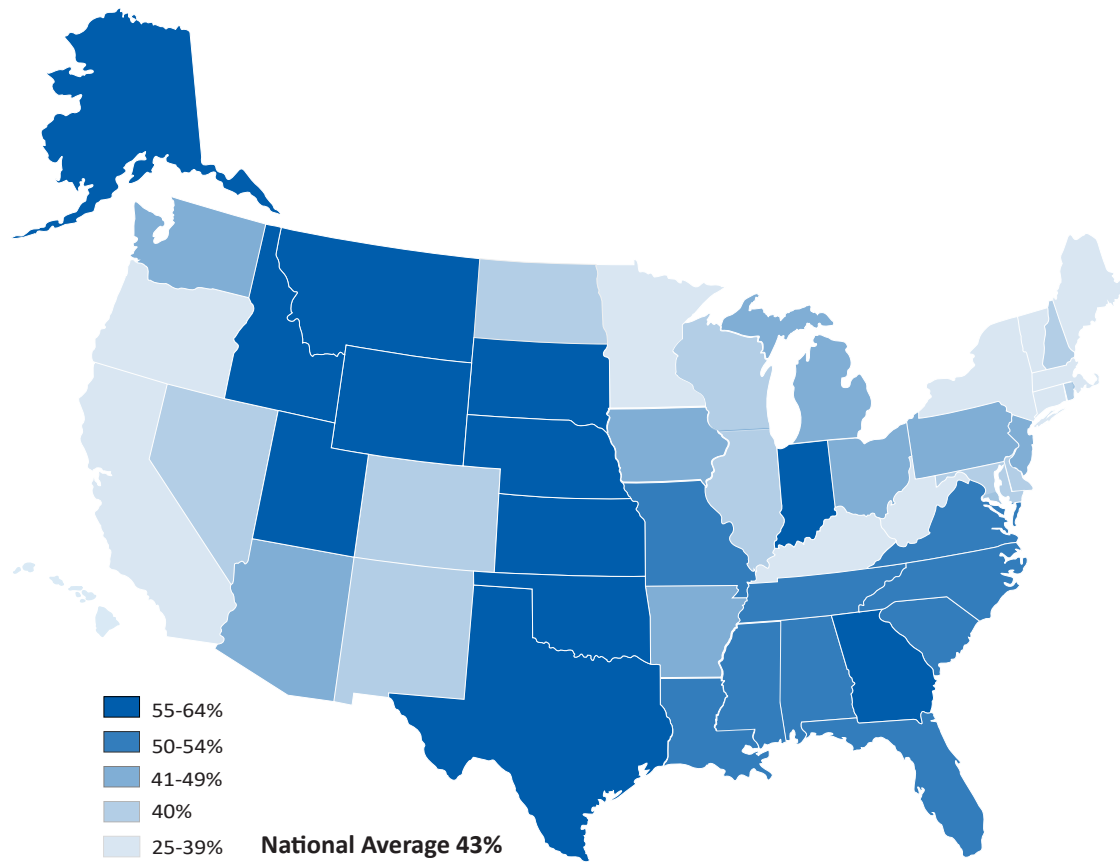
States that have lower income eligibility levels for adults (i.e., cover fewer adults) have a higher percentage of Medicaid/CHIP enrollees who are children. States such as Vermont or New York expanded Medicaid eligibility for adults both before and after the ACA, resulting in children being a smaller share of the total, even though they have high rates of child coverage. States such as Texas and Idaho do not cover many poor adults under age 65 outside of pregnancy and disability. This information is presented here because it is important in understanding the relative importance of children to states' Medicaid enrollment and spending, but it does not provide information on the extent of coverage of children or the effort the state makes in financing health services for them.

Medicaid Expenditures for Children as Proportion of Total Medicaid Expenditures

It has long been true that children account for a disproportionately smaller share of spending than other Medicaid enrollees, because they have lower health care costs in Medicaid and overall health expenditures. Persons with disabilities and seniors age 65 and older have much higher costs because of their

* Almost all seniors age 65 and older are covered by Medicare for basic health services; however, if they are living below poverty income they generally also qualify for Medicaid to finance supplemental services. Other seniors qualify for Medicaid coverage of long-term care not covered by Medicare.)

Figure 7. Percentage of Medicaid/CHIP Enrollees Who Were Children Under Age 18, By State, FFY 2014



Source: Kaiser Family Foundation. Based on reports from states to the US HHS Centers for Medicare and Medicaid Services.

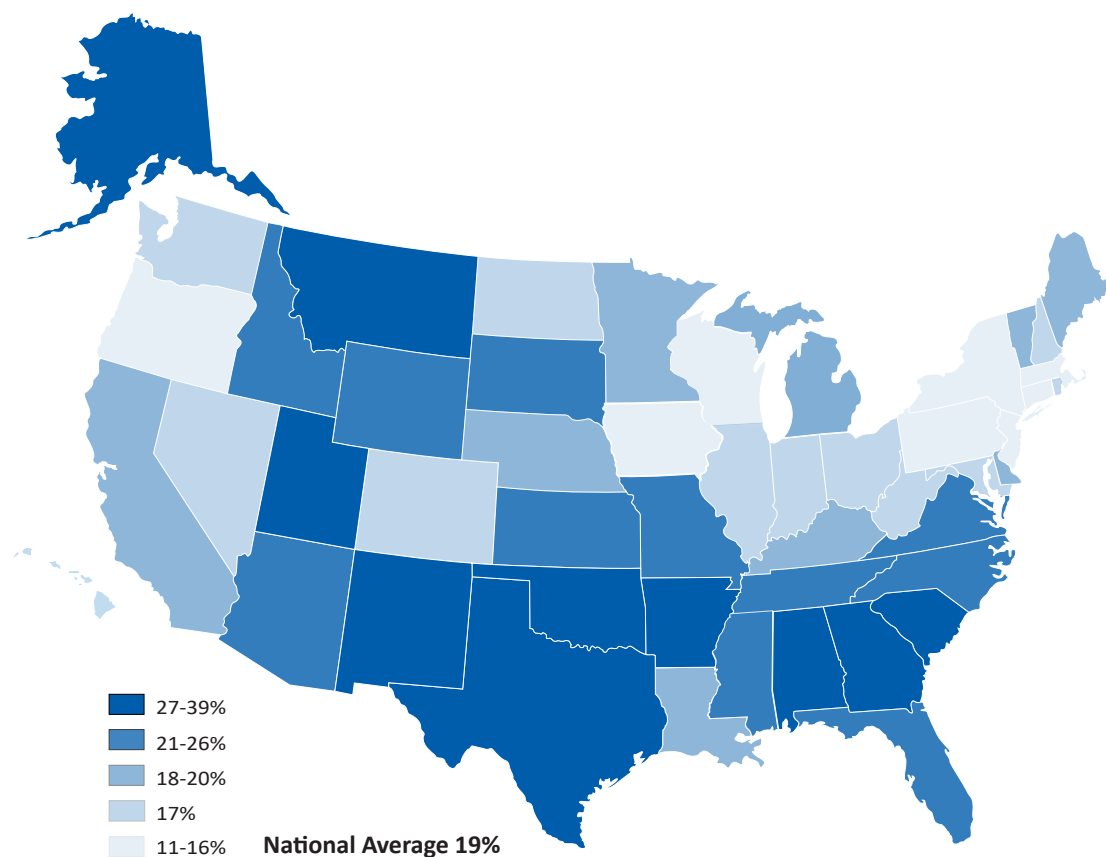
medical needs, representing over 60 percent of Medicaid benefit expenses in FFY 2014. As states look at their Medicaid budgets and particularly their costs, they often focus their attention on groups with higher costs, and not children. As emphasized throughout this sourcebook, however, children, and young children in particular, need to be a distinct focus of Medicaid policy and not treated as “little adults.”

As with children as a percentage of Medicaid enrollees, there is variation in the Medicaid expenditures for those enrolled in the “child” category (noting that some children are covered under the disability category and not as children). With more adults becoming eligible, the proportion of both enrollment and expenditures accounted for by children has declined. Nationally, children accounted for 43 percent of all Medicaid/CHIP enrollees, but only 19 percent of all Medicaid expenditures in FFY 2014 (see Figure 6). In all states the child population accounts for a minority of total Medicaid expenditures — and for many states that percentage is far below the national average of 19 percent.

Figure 8 shows the percentage of state Medicaid expenditures that were made for children in FFY 2014. (See data in Appendix A.) In five states, expenditures on children were at or below 15 percent of total Medicaid expenditures (Massachusetts, New York, Wisconsin, Pennsylvania, and New Jersey). Five states had expenditures greater than 30 percent (New Mexico, Georgia, Texas, Montana, and Oklahoma).¹⁶

Similar to the variations in enrollment data, the eligibility levels for adults and the number of low-income children both affect the percent of spending by eligibility group. For example, Texas — which has

Figure 8. Percentage of Medicaid Spending Per Child Enrollee, By State, FFY 2014



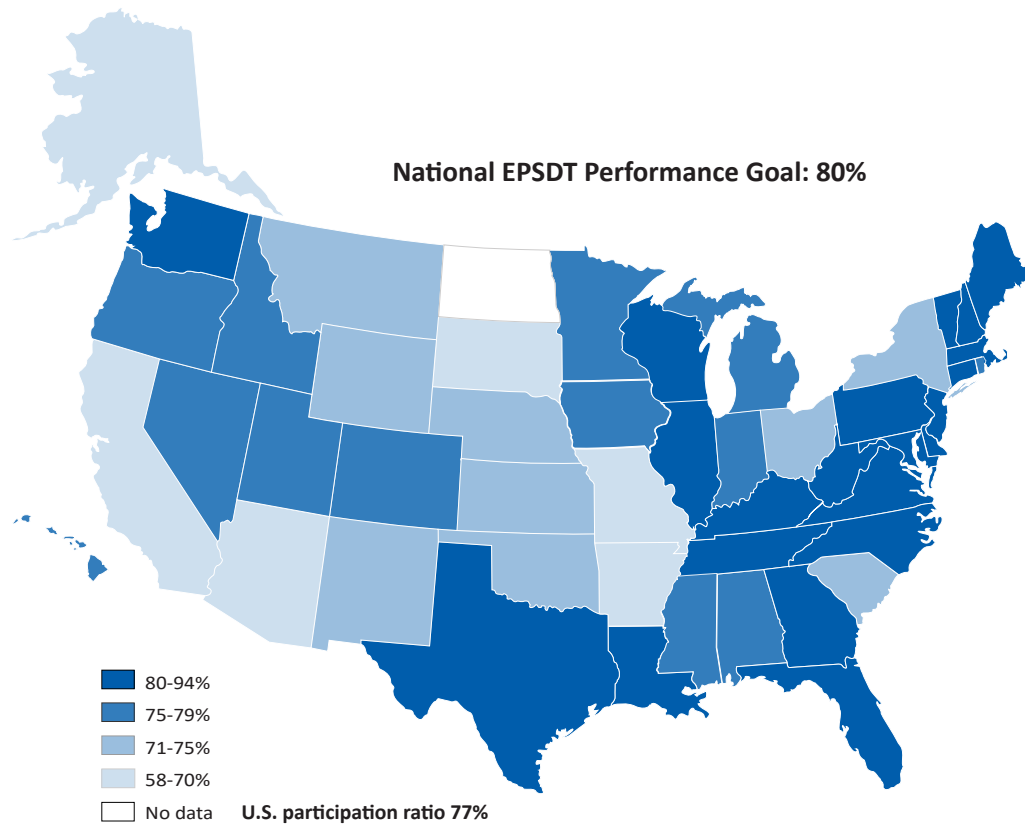
Source: KFF estimates based on analysis of data from the 2014 Medicaid Statistical Information System (MSIS) and Urban Institute estimates from CMS-64 reports.

the highest rate of uninsured children in the country — spent 31 percent of its funds on children in part because it has many low-income children and covers fewer adults. Adults accounted for only 6 percent of Medicaid spending in Texas, compared with 18 percent for seniors and 45 percent for persons with disabilities. In contrast, New York Medicaid spends 25 percent for adults, 12 percent for children, and close to average amounts for seniors (29 percent) and persons with disabilities (35 percent). Another factor that drives variations in Medicaid spending is that, while benefits for children are defined in federal law, states set payment levels and determine the amount, scope, and duration of services for an individual child that qualify for reimbursement under Medicaid.

Medicaid Expenditures per Enrolled Child

States may finance more or fewer services for children in Medicaid and provide higher or lower reimbursement rates. A gross measure of the variation in efforts states make to finance comprehensive child health services is evident by looking at their average expenditure per enrolled child, which averaged \$2,527 nationally for FFY 2014. (See Appendix A for data table and sources.) Six states (Nevada, Wisconsin, Florida, Louisiana, South Carolina, and Washington) had annual per-child expenditures below \$2,000 in FFY2014.¹⁷ Four states (New Mexico, Alaska, Vermont, and North Dakota) and the District of Columbia had expenditures more than twice that amount, above \$4,000. These variations in expenditures could be the result of the amount paid for specific services, the level and scope of services provided, or a combination of the two.

Figure 9. Percentage of Eligible and Enrolled Toddlers Who Received at least One EPSDT Well-Child Visit (Participation Ratio), By State, FFY 2016



Source: CMS 416 data FFY 2016.

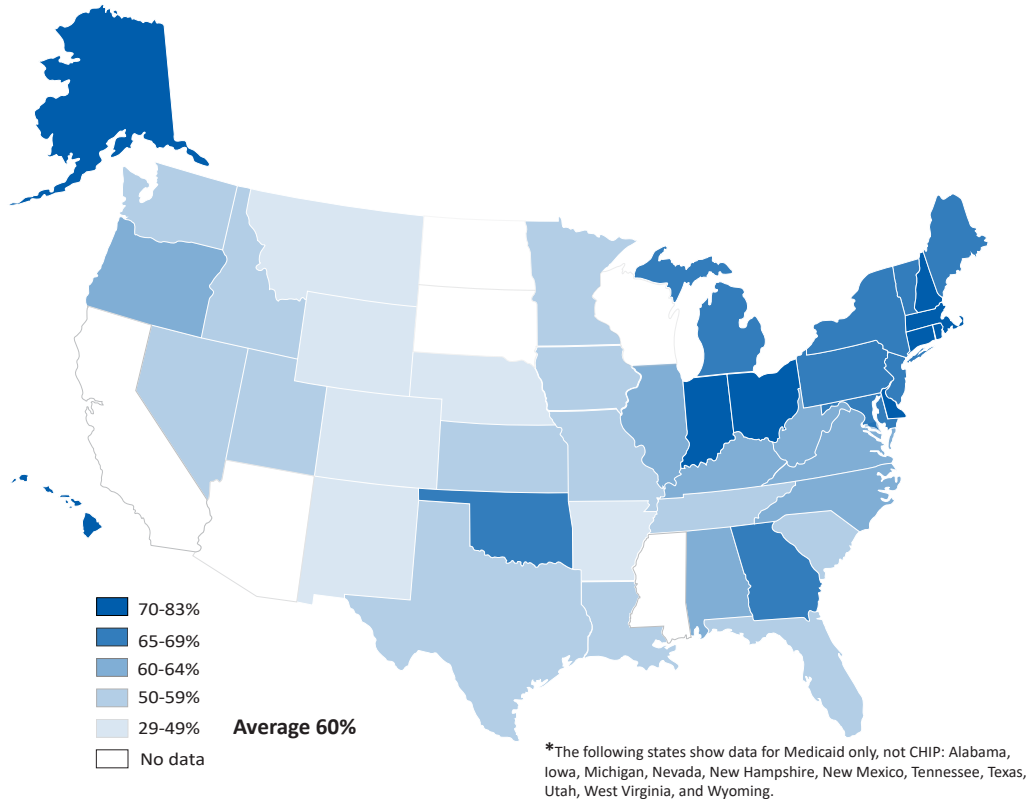
States have the authority under Medicaid to set payment levels and to require approval for payment of services, particularly higher-cost services. Such wide variations in expenditures per child suggest substantial differences across states in both payments and approved services under Medicaid, the result of different state policies and processes in implementing the program. These dollar amounts do not include expenditures for the nearly 1.6 million children who qualified for Medicaid as a result of more severe or long-lasting conditions in the eligibility category for persons with disabilities, another factor that varies by state.¹⁸ These variations cannot be explained by (i.e., do not correspond to) variations across states in child health status, although such variations exist.

Utilization of Preventive Well-Child EPSDT Visits

CMS 416 forms submitted by states provide both state and national Medicaid data on use of EPSDT preventive medical and dental services, broken out across seven age groups. This valuable data source points to variation in the level of service use among children, particularly for well-child visits. (Part six discusses these data in greater detail.)

State variations reflect differences in periodic visit schedules and other factors.¹⁹ In 2018, Medicaid programs in 41 states and D.C. used *Bright Futures* as the preventive care standard (35) or used a preventive care standard closely aligned with *Bright Futures* (7) guidelines.²⁰ For example, Figure 9 shows the EPSDT participation rate for toddlers age 1 and 2 years (12-35 months). In FFY 2016, the national total U.S. participation ratio (reflecting the percentage of toddlers enrolled in Medicaid for at least 90 days who

Figure 10. Percentage of Children Receiving Six or More Well-Child Visits in the First 15 Months of Life, Medicaid and CHIP, By State, FFY 2016



Source: Mathematica analysis of MACPro reports for FFY2016.

received at least one EPSDT well-child visit) was 77 percent among the nearly 4.4 million toddlers age 1 and 2 enrolled in Medicaid. The map shows that, for this age group, only 20 states met or exceeded the 80 percent EPSDT performance standard on this measure. This means that, despite the fact that the *Bright Futures* periodicity schedule²¹ recommends five well-child visits for toddlers (i.e., visits at 12, 15, 18, 24, and 30 months of age), 23 percent did not have even one visit.

The *Bright Futures* schedule recommendation is for nine well-child (EPSDT) visits before age 15 months, but the national performance measure for Medicaid and CHIP is the percentage of children receiving six or more visits by 15 months.²² Figure 10 shows the variation in states' performance on this Medicaid-CHIP child core measure for preventive visits among infants and toddlers. To understand more about the different ways of measuring Medicaid program performance for young children see part six. Among the 46 states reporting data for FFY 2016, the national median for this measure was 60 percent. This represents low performance on a measure that is already reduced from the standard of care. Individual states' performances range from 29 to 83 percent. For children ages 3, 4, 5, and 6, the

The wide variations in expenditures per child suggest substantial differences across states in both payments and approved services under Medicaid, the result of different state policies and processes in implementing the program.

performance measure is for annual visits as recommended in *Bright Futures*. The national median was 68 percent in FFY 2016, with the variation among 47 states reporting ranging from 45 percent to 86 percent. As this report discusses improvements to child health and the characteristics of high performing medical homes, one key is that young children and their families have frequent well-child visits during the first three years.

Conclusion

State-level information on Medicaid's coverage of young children points to areas of need and opportunity. There is wide variation, and all states are in a position to improve their Medicaid systems by providing more preventive, developmental, and family-centered responses for young children. This overview highlights how states vary in terms of eligibility, expenditures, and service utilization. Part one briefly describes the Medicaid benefit for children, highlighting federal law provisions and state flexibility. Part two then describes policy and program decisions in the context of high performing medical homes for

All states are in a position to improve their Medicaid systems by providing more preventive, developmental, and family-centered responses for young children.

young children. Part three discusses the opportunity to maximize Medicaid funding for and the impact of care coordination and case management for young children and their families. Part four discusses screening for risks related to child development and social determinants of health. Over time, states have expanded the array of services and programs they finance, in keeping with growing knowledge on the contributors to children's health. However, this has not been equal across states, particularly with respect to more preventive, ecological, and whole child services that are discussed in part five. In part six, financing topics are discussed, including how states vary significantly in terms of the reimbursement they provide for different services,

such as preventive well-child visits, child health screening, and treatment services. Although all states cover EPSDT well-child visits, states vary in the degree to which they provide billing codes and coverage for a range of other intervention and treatment services, including developmental and early childhood mental health services, important to meeting young children's needs. Part seven focuses on key measurement strategies for Medicaid and child health.

References

- 1 Harrington M, Kenney GM, Smith K, et al. CHIPRA mandated evaluation of the Children's Health Insurance Program: Final findings. Mathematica Policy Research. August 2014. Available at: https://www.urban.org/sites/default/files/publication/91321/2001371-medicaid-and-chip-for_children-trends-in-coverage-affordability-and-provider-access_0.pdf. Accessed July 1, 2018.
- 2 Rosenbaum S, Kenney GM. The search for a national child health coverage policy. *Health Affairs*. 2014 Dec 1;33(12):2125-35.
- 3 Kenney GM, Anderson N, Lynch V. Medicaid/CHIP participation rates among children: An update. Urban Institute. 2013. Available at: <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412901-Medicaid-CHIP-Participation-Rates-Among-Children-An-Update.pdf>. Accessed July 1, 2018.
- 4 Alker J, Pham O. Nation's uninsured rate for children drops to another historic low in 2016. Georgetown University Health Policy Institute, Center for Children and Families. Available at: <https://ccf.georgetown.edu/wp-content/uploads/2017/09/Uninsured-rate-for-kids-10-17.pdf>. Accessed August 30, 2018.

- 5 Haley JM, Kenney, Wang R, Lynch V, Buettgens M. Medicaid/CHIP participation reached 93.7 percent among eligible children in 2016. *Health Affairs*. 2018 Aug;37(8):1194-1199.
- 6 Georgetown University Health Policy Institute, Center for Children and Families. New data show progress covering uninsured children stalled. Available at: <https://ccf.georgetown.edu/2018/06/19/new-data-show-progress-covering-uninsured-children-stalled/>. Accessed August 30, 2018.
- 7 Georgetown University Health Policy Institute, Center for Children and Families. State health care coverage facts. Available at: <https://ccf.georgetown.edu/state-childrens-health-facts/>. Accessed July 1, 2018.
- 8 U.S. Census Bureau, Current Population Survey Annual Social and Economic Supplement (CPS ASEC). Historical Tables HIC Series, Table HIC-3 Health Insurance Coverage Status and Type of Coverage-Children Under 18 by Age, 2013 to 2016. Available at: <https://www.census.gov/data/tables/time-series/demo/health-insurance/historical-series/hic.html>. Accessed August 30, 2018.
- 9 Centers for Medicare and Medicaid Services. Certification of comparability of pediatric coverage offered by qualified health plans. November 25, 2015. Available at: <https://www.medicare.gov/hip/downloads/certification-of-comparability-of-pediatric-coverage-offered-by-qualified-health-plans.pdf>. Accessed June 3, 2018.
- 10 Johnston EM, Gates JA, Kenney GM. Medicaid and CHIP for children. Urban Institute. June, 2017. Available at: https://www.urban.org/sites/default/files/publication/91321/2001371-medicare-and-chip-for_children-trends-in-coverage-affordability-and-provider-access_0.pdf. Accessed August 1, 2018
- 11 Musumeci MB, Foutz J. Medicaid's role for children with special health care needs: A look at eligibility, services, and spending. Kaiser Family Foundation. February, 2018. Available at: <https://www.kff.org/medicaid/issue-brief/medicaids-role-for-children-with-special-health-care-needs-a-look-at-eligibility-services-and-spending/>. Accessed July 10, 2018.
- 12 Kaiser Family Foundation. Medicaid and CHIP income eligibility limits. Available at: <https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-children-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>. Accessed June 3, 2018.
- 13 Kaiser Family Foundation. Medicaid and CHIP eligibility, enrollment, renewal, and cost sharing policies as of January 2017: Findings from a 50-state survey, March 2018. Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2018. Available at: <http://kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2018-findings-from-a-50-state-survey>. Accessed June 3, 2018.
- 14 Hudson JL, Moriya AS. Medicaid expansion for adults had measurable 'welcome mat' effects on their children. *Health Affairs*. 2017;36(9):
- 15 Haley J, Want R, Buettgens M, Kenney GM. Health insurance coverage among children ages 3 and younger and their parents: National and state estimates. Urban Institute. 2017.
- 16 Kaiser Family Foundation. State Health Data: Medicaid Spending by Enrollment Group. Available at: <https://www.kff.org/medicaid/state-indicator/medicaid-spending-by-enrollment-group/?dataView=1¤tTimeframe=0&selectedDistributions=children&sortModel=%7B%22colId%22:%22Children%22,%22sort%22:%22desc%22%7D> Accessed June 10, 2018.
- 17 Kaiser Family Foundation. State Health Data: Medicaid Spending per Full-Benefit Enrollee. Available at: <https://www.kff.org/medicaid/state-indicator/medicaid-spending-per-full-benefit-enrollee/?currentTimeframe=0&selectedDistributions=children&sortModel=%7B%22colId%22:%22Children%22,%22sort%22:%22desc%22%7D>. Accessed June 10, 2018.
- 18 Musumeci MB, Foutz J. Op cit.cit. 2018.
- 19 Georgetown University Health Policy Institute, Center for Children and Families. Forthcoming issue brief. October 2018.
- 20 bid.
- 21 American Academy of Pediatrics. *Bright Futures*: Recommendations for preventive pediatric health care periodicity schedule, 2017. Available at: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf. Accessed June 18, 2019.
- 22 Office of Inspector General. Early Periodic Screening Diagnosis and Treatment—Performance measurement. (OEI-07-90-00130) US Department of Health and Human Services. 1992. Available at: <https://oig.hhs.gov/oei/reports/oei-07-90-00130.pdf>. Accessed July 23, 2018.



K. Johnson and C. Bruner. A Sourcebook on Medicaid's Role in Early Childhood: Advancing High Performing Medical Homes and Improving Lifelong Health. Child and Family Policy Center. October 2018.

Part One

The Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Benefit for Children

Part One / Key Takeaway Messages

- EPSDT is the child health benefit in Medicaid and sets federal requirements and expectations for using Medicaid to promote and improve child health. Required in every state Medicaid program, EPSDT finances a wide array of appropriate and necessary pediatric services. The EPSDT benefit provides a legal entitlement to children covered under Medicaid and is intended to guarantee children coverage for all services allowed under Medicaid in federal law, even if the state does not cover them for other populations.
- EPSDT requires states to finance a wide array of prevention and treatment services. This includes comprehensive well-child visits to screen for, identify, and respond early to conditions that affect the child's health. EPSDT required benefits also include informing families about their benefits, providing assistance in scheduling appointments, arranging for treatment, and financing for transportation to keep appointments.
- Despite federal requirements, states vary in how they implement the EPSDT benefit, both in terms of preventive and primary care and in terms of services for children with special health care needs (CSHCN), disabilities, and other conditions necessitating treatment.
- Medicaid and its EPSDT benefit not only enable states but set expectations for states to provide high quality primary and preventive health care. The opportunities to cover appropriate, effective, and cost-effective services for young children under Medicaid are discussed further throughout this report and in the context of a high performing medical home. Federal law sets a strong framework and expectation for states to provide comprehensive preventive services for young children, starting with the office visit. EPSDT forms a legal basis for financing of “high performing medical homes” for young children and other prevention and early intervention services, as they are discussed in parts two through five of this report.

Basic EPSDT Framework

EPSDT is the child health benefit in Medicaid. It sets broad federal requirements and expectations for using Medicaid to promote and improve child health. EPSDT was enacted in 1967 to build on the vision of President Lyndon B. Johnson and Congress to “discover, as early as possible, the ills that handicap our children” and to provide “continuing follow up and treatment so that handicaps do not go neglected.”^{1 2} For more than 60 years, federal EPSDT law and state efforts have evolved to include changes in standards of pediatric care, structures in the health care system, and knowledge regarding the physical, developmental, social and emotional needs of low-income children.^{3 4}

Required in every state Medicaid program, EPSDT finances a wide array of appropriate and necessary pediatric services. As discussed above, this benefit requirement includes children enrolled by states through Medicaid expansion CHIP, but not those in private, separate CHIP plans, unless a state sets those as a CHIP requirement. Individuals under age 21 enrolled in Medicaid receive coverage for services — at regular intervals and whenever a problem appears — to identify and address physical, developmental, dental, and mental health conditions.⁵ The EPSDT benefit is intended to guarantee children coverage for all services allowed under Medicaid in federal law. In addition to health services, EPSDT required benefits include informing families about their benefits and providing assistance in scheduling appoint-

ments, arranging for treatment, and financing for transportation to keep appointments. (42 U.S.C. Sections 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r)) As described in federal rules, states are required to: “[a]ssure that health problems found are diagnosed and treated early, before they become more complex and their treatment more costly. . . that informing methods are effective, . . . [and] that services covered under Medicaid are available.” (CMS, State Medicaid Manual Sections 5010, 5121, 5310)

EPSDT Well-Child Visits

Known as EPSDT screening visits, Medicaid finances preventive well-child visits that include a comprehensive health and developmental history, an unclothed physical exam, immunizations, laboratory tests, and health education and guidance for parents and children. Such EPSDT “check-up” visits are covered at age-appropriate periodic intervals recommended by professionals on a schedule set by states, and at other times, as needed. The periodic visit schedule defined in *Bright Futures* is widely used by both state Medicaid agencies and private plans for this purpose. The *Bright Futures* schedule recommends: a visit at birth; six visits for infants (at ages 3-5 days, and at 1, 2, 4, 6 and 9 months); five visits for toddlers ages 1 and 2 (at ages 12, 15, 18, 24, and 30 months); and three visits for preschoolers ages 3, 4, and 5.

Not all states operate in accordance with the *Bright Futures* periodicity schedule. (See Appendix B.) In FFY 2016, among 49 states and the District of Columbia, eight did not meet the standard for infants, and 30 did not meet the standard for toddlers. All states met the standard for at least three visits among preschoolers. In total, the American Academy of Pediatrics (AAP) recommends 14 visits for young children prior to the sixth birthday (with the newborn visit often done in the hospital making the total 15). In FFY 2016, 22 states — nearly half — did not have 14 or 15 pediatric well-child visits for young children birth through 5 on their EPSDT periodicity schedules. Such gaps in periodicity schedules can lead providers to reduce the number of visits they schedule for families, believing additional visits might not be covered.

In addition, required vision, hearing, and dental services are typically provided separately under a distinct schedule based on professional standards, but must include screening, diagnosis, and treatment. Similar to *Bright Futures* concordance, many states do not have up-to-date periodicity schedules for the additional services. For example, a 2013 review of states’ adherence to the American Academy of Pediatric Dentistry’s recommended schedule found that only 32 states had dental periodicity schedules and only 11 states adhered to the professional standard of practice for requiring referral to a dentist for a first dental visit by age 1.⁶ Since dental decay is found among approximately 30 percent of low-income young children ages 2-5 years, this is another important early childhood periodicity gap.

Figure 11. The EPSDT Framework

- E** **Early** identification of risks and conditions
- P** **Periodic** comprehensive well-child visits birth to 21
- S** **Screening** for physical, mental, developmental, dental, etc.
- D** **Diagnostic** tests to follow up on identified risks
- T** **Treatment** to correct, reduce, or control problems found

Table 2. Medicaid Coverage Categories for Children

Medicaid Mandatory Coverage Categories for Children and Adults	Examples of Optional Services for Adults that are Mandatory When Medically Necessary for Children under EPSDT:
Home health services	Parent education/anticipatory guidance
Physician services	Case management
Inpatient hospital services	Clinic services
Outpatient hospital services	Developmental screening
Nurse Midwife services	Dental services
Certified Pediatric and Family Nurse	Early childhood mental health, including parent-child dyadic therapy
Practitioner services	Physical and occupational therapy
Laboratory and X-ray services	Speech, hearing and language disorder services
Family planning services	Optometry services and glasses
Freestanding Birth Center services	Other diagnostic, screening, preventive and rehabilitative services
Tobacco cessation counseling for pregnant women	Prescription drugs
Rural health clinic services	Personal care services
Federally qualified health center services	
Nursing Facility Services	
Transportation to medical care	

Medically Necessary Treatment Services

Under EPSDT, Medicaid not only covers preventive, well-child visits, it also covers medically necessary services to intervene for or treat identified physical, dental, developmental, and mental health conditions. This includes all “medically necessary” services that are included within the categories of mandatory and optional services (as defined in Medicaid law section 1905(a)), regardless of whether such services are covered for adults. Determinations of medical necessity are made by the state but must be made on a case-by-case basis, taking into account the needs of the individual child and guided by information from the child’s health providers. Moreover, when a problem is identified through screening and diagnostic services, EPSDT requires states to “arrang[e] for ... corrective treatment,” either directly or through referral to appropriate providers or licensed practitioners, for any illness or condition detected ...” (CMS, State Medicaid Manual Section 5124)

Examples of services covered for children that may not be covered for adults in a given state are shown in Table 2. Note that CMS has made it clear for decades

that not all covered services are named on the list. For example, mental health services do not appear as a discrete category but might be covered under physician, clinic, inpatient or other service categories. A longer list of possible services and approaches to coverage for young children and their families can be found in Appendix C.

Children with special health care needs (CSHCN) “have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and also require health and related services of a type or amount beyond that required by children generally.”^{7 8} While an estimated 15 percent of children under age 18 have special health needs, Medicaid and CHIP provide coverage for nearly half (48 percent) of all CSHCN.⁹ For many, such special needs begin at birth with a preterm birth, a hereditary disorder, or other conditions. Others can develop conditions such as autism, developmental disabilities, and speech-language-hearing problems in early childhood. For many young CSHCN with medical conditions, a diagnosis may confirm their condition and point to medically necessary treatment.

For young children experiencing emotional and mental health conditions, developmental delays, attachment disorders, and trauma, the related child and family risks may be identified before a diagnosis would apply. A specific diagnosis is not a requirement for intervention services financed under EPSDT. A

Regulations related to EPSDT Medical Necessity and Treatment

§5122 F. “Limitation of Services.—The services available...are not limited to those included in your State [Medicaid] plan.... the services must be necessary . . . to correct or ameliorate defects and physical or mental illnesses or conditions . . . [the states] make the determination as to whether the service is necessary.”

“42 CFR 440.230 allows you [the states] to establish the amount, duration and scope of services provided under the EPSDT benefit. Any limitations imposed must be reasonable and services must be sufficient to achieve their purpose (within the context of serving the needs of individuals under age 21). You may define the service as long as the definition comports with the requirements of the statute in that all services included in §1905(a) of the Act that are medically necessary to ameliorate or correct defects and physical or mental illnesses and conditions discovered by the screening services are provided.”

growing number of states have adopted Medicaid approaches for financing early childhood mental health services, including parent-child dyadic therapies and in-home mental health treatment. In response to the opioid epidemic, some states are adopting family-focused approaches to substance abuse in the household, particularly when young children are present.

Services to address social determinants of health for young children and their families, as long as their objective is in improving child health, also can be financed using Medicaid. Home visiting and other preventive, developmental, and two-generation approaches are discussed further in parts four, and five.

States vary in how they administer and implement Medicaid for all covered populations (e.g., low income children, adults, seniors, and persons with disabilities). Despite EPSDT requirements, states vary in how they implement the EPSDT benefit, both in terms of preventive health care and in terms of services to CSHCN and other conditions requiring treatment. Some states have good policies in place, but health providers and families are not well informed about the coverage. Families, child advocates, and child health providers have worked with state agencies for decades to help ensure that Medicaid finances quality services under recognized standards of care and that each child’s needs are identified early and addressed promptly and effectively. This remains an ongoing challenge, but also represents an opportunity.

Services to address social determinants of health for young children and their families, as long as their objective is in improving child health, can be financed using Medicaid.

States have the authority and flexibility, particularly through EPSDT, to structure coverage of services for children to achieve goals for prevention, healthy development, and minimization of disability. The opportunities to cover appropriate, effective, and cost-effective services for young children are discussed further throughout this report.

The Rationale for a Broad Perspective on Medicaid Coverage of Services for Young Children

When children are very young (0-3), they are setting the foundation and trajectory for all future development — largely through interactions with their parents and other caring adults. The safety, stability, and nurturing in the home environment is critical to young children's health and development. Child health providers play a leading role in ensuring health through identifying and responding to conditions of a newborn, treating disease and injury, providing immunizations, and diagnosing and responding early to other clinical medical and health concerns. However, that is only a part of what contributes to a child's health trajectory and long-term healthy growth and development.

In the case of young children with recognized and diagnosed medical conditions, successful treatments and related services are generally covered under Medicaid. This is particularly true when the treatment is found to be medically necessary for an individual child. Young children often have identified risks or live in conditions that have not resulted in a specific diagnosis at their age or stage of development. Medicaid, under the broad mandate of the EPSDT child health benefit, finances services for young children without a specific medical diagnosis in order to prevent, ameliorate, or correct risks and conditions. This might include: developmental services for a child at risk of developing a developmental disability or parent-child dyadic mental health therapy when a mother is depressed, even if the parent is not covered by Medicaid.

State Medicaid agencies also finance an array of prevention and early intervention services that do not require individual determinations of medical necessity. Within a primary care practice, this might mean reimbursement for time spent delivering Reach Out and Read, work of a Healthy Steps program specialist, outreach visits by a community health worker to assess home safety, or anticipatory guidance when the parent has a concern about the child's behavior or mental health. Other prevention programs financed by Medicaid include: home visiting programs for families with young children, early childhood mental health consultation in community settings when provided to individual children, and health-related services under the Individuals with Disabilities Act Part C Early Intervention Program for Infants and Toddlers. (See discussion of other services and programs in part six of this sourcebook.)

References

- 1 Rosenbaum SJ, Mauery DR, Shin P, Hidalgo J. National security and US child health policy: the origins and continuing role of Medicaid and EPSDT. George Washington University, 2005.
- 2 Rosenbaum S, Johnson K. Providing health care for low-income children: reconciling child health goals with child health financing realities. *The Milbank Quarterly*. 1986 Jan; 64(3):442-78.
- 3 Rosenbaum S, Wise PH. Crossing the Medicaid–private insurance divide: the case of EPSDT. *Health Affairs*. 2007 Mar;26(2):382-93.
- 4 Rosenbaum S. ACEs and child health policy: the enduring case for EPSDT. *Academic Pediatrics*. 2017 Sep;17(7):S34-5.
- 5 Centers for Medicare and Medicaid Services (CMS). What you need to know about EPSDT. Available at: <https://www.medicaid.gov/medicaid/benefits/downloads/what-you-need-to-know-about-epsdt.pdf>. Accessed July 23, 2018.
- 6 Hom, JM, Lee JY, Silverman J, Casamassimo PS. State Medicaid Early and Periodic Screening, Diagnosis and Treatment guidelines: Adherence to professionally recommended best oral health practices. *Journal of the American Dental Association*. 2013;144(3), 297–305.
- 7 U.S. Department of Health and Human Services, Health Resources & Services Administration, Maternal and Child Health. Bureau. Children with Special Health Care Needs, 2016. Available at: <https://mchb.hrsa.gov/maternal-child-health-topics/children-and-youth-special-health-needs#ref1>. Accessed June 18, 2018.
- 8 McPherson M, Arango P, Fox H, et al. A new definition of children with special health care needs. *Pediatrics*. 1998 Jul;102(1 Pt 1):137-140.
- 9 Musumeci MB, Foutz J. Medicaid’s role for children with special health care needs: A look at eligibility, services, and spending. Kaiser Family Foundation. February, 2018. Available at: <https://www.kff.org/medicaid/issue-brief/medicaids-role-for-children-with-special-health-care-needs-a-look-at-eligibility-services-and-spending/>. Accessed July 10, 2018.



K. Johnson and C. Bruner. A Sourcebook on Medicaid's Role in Early Childhood: Advancing High Performing Medical Homes and Improving Lifelong Health. Child and Family Policy Center. October 2018.

Part Two

High Performing Medical Homes for Young Children: Covering Well-Child Care to Meet *Bright Futures* Guidelines

Part Two / Key Takeaway Messages

- Child health practice is undergoing a transformation, broadening its focus from treating disease and managing existing health conditions to promoting healthy development. Children's primary care providers are expanding their role in responding to social as well as bio-medical determinants of health. Science and expert recommendations guide such shifts, which are particularly important in the earliest years of life. *Bright Futures* guidelines describe this role and a patient/family-centered medical home, defining expanded relationships with children, their families, and other community services.
- A growing base of exemplary primary care practices demonstrate the feasibility and value of providing such care for young children, called here "high performing medical homes" to distinguish them from the current general standard of care. Moving from isolated exemplary practices to widespread diffusion requires Medicaid financing that supports and sustains best practices, including comprehensive well-child visits and the additional care coordination, practice enhancements, and linkages to community services needed to address children's healthy development.
- To do so, states need to differentiate between general pediatric practice and that provided by high performing medical homes, setting Medicaid reimbursement rates and incentives (either directly or through managed care contracts) accordingly. States also need to use quality measures to monitor high performing medical homes to assure that they provide the expected level of care.

Child health practice is undergoing a transformation, broadening its focus from treating disease and managing existing health conditions to promoting healthy development.¹ This transformation is based on a much more ecological and family-centered approach to providing primary and preventive services through well-child visits. The definition of health is now generally considered as a state of physical, mental, and social well-being, not merely the absence of disease or disability.^{2 3} Thus health care services, particularly for children, must be broadened to include responses not only to bio-medical factors but also to address social determinants of health that can have negative impact on health across the life span. While the health care system is not responsible for addressing all social determinants, and certainly not through clinical services, it has a key role to play, often in initiating responses.⁴ For young children, it is particularly important that primary care respond to social determinants of health that reflect family and community environments that can jeopardize healthy and development.⁵

Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents^{6 7 8} provides evidence-based guidelines for well-child and preventive care. Led by the American Academy of Pediatrics (AAP) and supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB), *Bright Futures* has been designated as the standard of care for pediatric preventive services in public and private plans in federal law.⁹ ¹⁰ The *Bright Futures* guidelines outline the content for 31 age-specific, well-child, preventive health visits from birth to 21. Its most recent edition has expanded emphasis on using well-child visits to promote overall health and well-being and to respond to social determinants of health, including themes such as family support and healthy development, as well as physical, mental, developmental, and oral health.

A growing array of primary care practices is responding to this broader definition of what determines health. Some exemplary practices in the Child and Family Policy Center's Health Equity Initiative (Pri-

mary Health Care Iowa, Maricopa Health Systems, The Children's Clinic) have developed systemic approaches within existing health systems, while others have adopted and built on new evidence-based program models (e.g., Help Me Grow, HealthySteps, and Project DULCE) (see Appendix D). Such practices have recognized that ensuring the safety, stability, and nurturing in the home environment is foundational to healthy child development. In most instances, these efforts extend beyond the primary health setting, connecting families with services and supports to promote all areas of child development (i.e., physical, cognitive, social-emotional, and language). They start, however, with the pediatric primary care setting extending beyond what often is the routine practice of a physical examination, vaccinations, and primary attention to any medical issues. They augment with screening, care coordination/case management, staff focused on development, and other approaches to better serve children from low-income, higher-risk communities.

To move from exemplary sites to widespread implementation will require states to develop Medicaid payment approaches, benefit definitions, provider requirements, and other processes that support this new standard of care. Where states have established contracts with managed care or accountable care organizations for delivering Medicaid services, states must establish contract requirements, guidelines, and incentives to advance this work. Under *Bright Futures* guidelines and Medicaid's EPSDT provisions, states have both the authority and the responsibility within their Medicaid programs to accelerate this transformation across the country. The first step is to define and sufficiently finance the pediatric medical home.

Seven Core Features of the Medical Home

Personal Physician — each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician-Directed Medical Practice — the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole Person Orientation — the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals.

Care is Coordinated and/or Integrated — across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services).

Quality and Safety — are hallmarks of the medical home. Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.

Enhanced Access — to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment Reform — appropriately recognizes the added value provided to patients who have a patient-centered medical home.

Source: American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association (2007). Joint principles of the patient-centered medical home. 10-24-07.

Defining and Financing a High Performing Medical Home

Pediatric primary care providers (e.g., pediatricians, family physicians, nurse practitioners, etc.) are the professionals most likely to see and serve young children (particularly those under 3). With 9 out of 10 young children seeing a health provider for a well-child, preventive visit at least annually (and more frequently in the earliest years), such visits offer opportunities for improving health outcomes during childhood and for a lifetime. The pediatric medical home is the ideal context for this to occur.

The AAP, HRSA-MCHB, and CMS all recommend that each child have a patient/family centered medical home. An increasing body of research identifies the key characteristics of a medical home. According to the AAP and HRSA-MCHB, a pediatric medical home provides health care must be accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. In 2007 the AAP, American Academy of Family Practice, American College of Physicians and American Osteopathic Association developed the “Joint Principles of the Patient-Centered Medical Home (PCMH)”¹¹ and adopted the National Center for Quality Assurance (NCQA) — PCMH criteria as standards for practices.¹² The shared principles are to deliver primary care that is: person and family centered, continuous, comprehensive, equitable, accessible, coordinated and integrated, team-based and collaborative, and high value. Quality and safety are integral parts of the medical home model.¹³ The document also described seven core features of such a medical home, previously shown.

By transforming their practice and operating as a high performing medical home, pediatric primary care providers can better achieve the quality and experience of care for the young child and family.

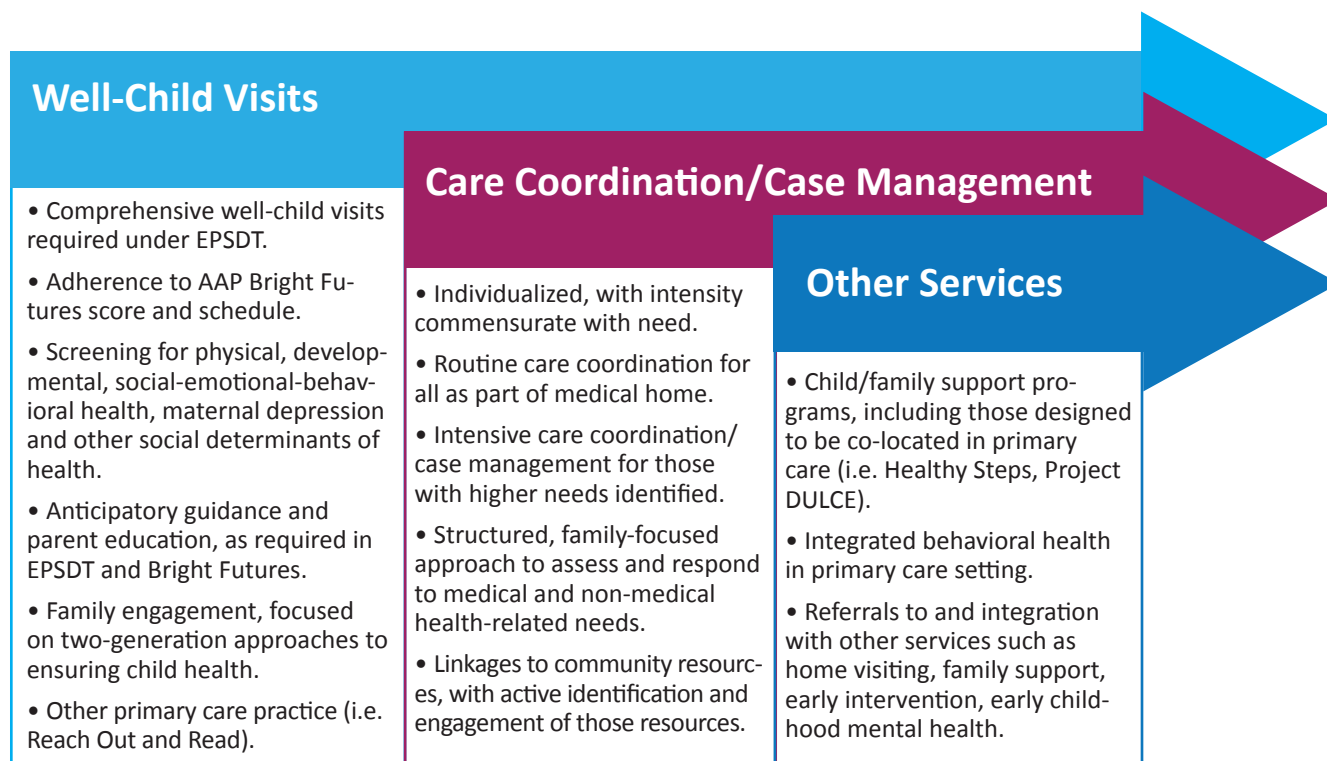
As discussed above, many pediatric medical home providers are augmenting their services or increasing linkages with other community providers to better address risks and concerns related to child development, emotional-behavioral factors, or social determinants of health.^{14 15 16 17 18} Others have adopted a pediatric primary care bundle and used quality improvement approaches to achieve significant improvements in practice — for instance, one effort showed an improvement from 58 percent to 92 percent of visits where full bundle of preventive services was received for patients 0 to 14 months of age, with sustained the improvement for over one year.¹⁹ Such efforts require time and resources to establish and maintain in clinical

practice and within the office setting, but they are particularly important for assuring the health and development of children in Medicaid and reducing long-term costs in health, education, and social services.

By transforming their practice and operating as a high performing medical home, pediatric primary care providers can better achieve the quality and experience of care for the young child and family, improving the health trajectories of young children as a result, and reduce the incidence of preventable health conditions across the lifespan that currently are the source of many health care costs. A high performing medical home for young children in Medicaid would carry out the functions beyond what is in standard practice today, and in particular give more focus to the needs and risks of low-income young children and their families. Exemplary pediatric primary care practices for low-income young children share important characteristics related to their approaches and functional components that define high performance. Specifically, they:

1. Provide comprehensive well-child visits and preventive services based on *Bright Futures* and EPSDT standards, including screening, anticipatory guidance and parent education. This includes engaging with families to screen for, identify, and discuss issues (anticipatory guidance) that extend beyond

Figure 12. Design for High Performing Pediatric Medical Homes in Medicaid



the physical/bio-medical well-being of the child to the social and environmental factors that affect healthy child development (e.g. family stress and adversity, maternal depression, food insecurity), with a two-generation emphasis on improving child health.

2. Provide care coordination/case management at appropriate levels (low, moderate, and more intensive levels), depending on child and family presenting concerns. This includes supports for an effective, warm “handoff” from the health practitioner to a care coordinator (based inside the medical home and/or in the community) to identify concerns, strengths, and needs, and to ensure referral and follow-up that connects families with resources and supports that meet needs and build strengths. A part of this care coordination is to identify and network with other resources in the community to facilitate effective care coordination and ensure completed referrals, connecting young children and their families to services and supports in their communities.
3. Increase use of other supports for healthy development. This can include augmented services located within the primary care setting, such as integrated behavioral health, developmental specialists, or community health workers to support families. Primary care practices also should link to or integrate with other services such as home visiting, dyadic therapies to improve children’s healthy development, early intervention for developmental delays and disabilities, early childhood mental health therapy, or parenting programs.

Figure 12 illustrates these different characteristics of high performing pediatric medical home, reflecting best practices and approaches identified in the field and based on the goals and guidelines set in *Bright Futures*. Medicaid can finance services in each of the three areas.

Aiming for Quality in Well-Child Visits

In many respects, the diffusion of innovation in pediatric primary care is in an early stage, with opinion leaders calling for change and early adopters undergoing transformation. Most practices offer traditional

Most practices offer traditional medical care for young children but have not adopted approaches to address social determinants of health or accelerated efforts to identify and address developmental concerns.

al medical care for young children but have not adopted approaches to address social determinants of health or accelerated efforts to identify and address developmental and behavioral concerns. Risks and conditions that may not yet meet a clinical threshold of disease or illness or developmental delay often remain unaddressed. Time available to spend with children and their families is limited, and it may seem impossible to add anything new to their responsibilities. At the same time, most pediatric primary care providers recognize there would be value to doing more, particularly if compensation and staff with expertise are available (e.g., for intensive care coordination, augmentations).

The following scenarios describe good current practice for primary care addressing bio-medical issue (scenario one) and practices that extend beyond that (based on exemplary program experience) to be a truly high performing medical home (scenario two).

Scenario one: 1-Year-Old Well-Child Visit

A mother and child come into the office and are sent into an examination room, where a nurse comes in, measures and weighs the child, and informs the mother of the immunizations the child will receive. She asks the mother to unclothe the child and says that the doctor will be in shortly for the examination. The doctor comes in and does a thorough, full-body examination of the child, sharing with the mother that while the child has no medical abnormalities, the child is in the 85th percentile for her age in weight and the 50th percentile for height. He asks about the child's eating patterns and cautions against giving more than four ounces of juice per day. He also asks the mother if she has any concerns about her child's physical development and speech. Although he notices the mother looks stressed and does not appear to pick up on the child's cues for attention, he doesn't see anything medical to address. He concludes the visit by assuring the mother her child is healthy but again encouraging her to watch the child's weight and nutrition and says he looks forward to the next visit.

Scenario two: 1-Year-Old Well-Child Visit

Prior to coming into the office, the mother received notifications of the upcoming visit, was mailed a pre-visit information sheet for this age group from *Bright Futures*, and was encouraged to complete the online Well-Visit Planner and an Ages and Stages Questionnaire (screening tool about development). When she comes in, the front desk staff checks to see any results (in this instance there are none, as the mother did not complete the planner or questionnaire) and provides the mother with a parent survey that asks questions about the child's development and family concerns. The staff person highlights for the doctor several responses, including that the mother has had a change in her life (housing move), reports she is under significant stress, and is concerned with her child's "acting out." While she waits, the mother is given a handout that briefly describes developmental expectations and milestones for a 1-year-old and some tips on eating, exercise, bedtime and sleep patterns. As with scenario one, the mother and child are sent to an examination room and the nurse reviews the immunization schedule and informs the parent what the examination will cover.

Table 3. Financing Core Functions in a High Performing Pediatric Medical Home

Core function for high performing pediatric medical home	Medicaid mechanism	Reimbursement and fiscal sustainability	Quality and value measures for incentives and accountability
<p>Well-Child Visit and Prevention Practices</p> <ul style="list-style-type: none"> • Child physical examination • Developmental surveillance and screening • Screening for social determinants of health and family risks • Anticipatory guidance • Care coordination • Required referrals for other services, including: vision, hearing, and dental • Referrals as needed for further mental and developmental assessment. • Other referrals as needed for nutrition, housing, income, and other family support services 	<ul style="list-style-type: none"> • Well-child (EPSDT) visit payment • Separate payments (where approved by state) for screening of child development (general and social-emotional) and social determinants (material, personal, social, and parenting, and screening for maternal depression) 	<ul style="list-style-type: none"> • Reimbursement for visits (which document core functions achieved) cover costs — 15-minute and 30-minute visits @ \$100+ and \$150+ (e.g. payment for a high performing medical home for young children above that for current well-child visits) • Screening payments (e.g., \$25+ per screen, with more than one screen allowed) 	<ul style="list-style-type: none"> • Medicaid-CHIP core measures on primary care access and preventive services, including: well child visits, developmental screening, immunizations, and access to primary care. • Use of care coordination • Referrals and appointments made for follow up on identified risks

When the doctor comes in, he immediately asks the mother how she and the child are doing and how the move has gone. The mother indicates that it has been hard, she has moved in with a friend in order to save money, there isn't much space for her and her child, and they likely will have to move again. Following queries, the mother expresses frustration at managing her child's temper tantrums, particularly at bedtime, and that she herself is often exhausted. While completing the child's physical itself, the doctor indicates that the child is healthy but has nutrition concerns and would like to go over the information on the handout about nutrition. The doctor also says he would like to call-in part of his team, a HealthySteps specialist, to spend a little more time discussing child behavior management and development. First, however, the doctor brings out a book and hands it to the mother and asks her to share the book with the child. He watches the mother doing this, and comments on how, even at this age, reading and showing pictures to a child is a good activity. The doctor mentions he would like to have another check-up in a month or six weeks, so he can see how the nutrition and reading are going, and if the nighttime routine is getting easier.

The doctor then leaves and confers briefly with the HealthySteps specialist, who comes in for a 20-minute session with the mother and child. The specialist provides advice, guidance, and modeling on parenting and answers a number of questions the mother now asks. The worker also compliments the mother on the way she holds her child and responds when the child smiles. The specialist learns that the mother does not have a crib for the child to sleep in and that the housing situation is temporary. The worker is able to connect the mother with a paralegal, through a clinic relationship with legal services under the practice's Medical-Legal Partnership, which helps provide housing leads. The mother also receives a voucher that can be used to get a safe, portable crib through the local health

department. The mother leaves with a general handout on children’s developmental expectations at age 1, a picture book, an appointment schedule for an interperiodic EPSDT visit in six weeks, and several additional resources provided by the HealthySteps specialist about what they had discussed.

Clearly, both visits have value for the child’s overall healthy development, but the second does much more around probing the stability and nurturing the child is likely to receive that are foundational for optimal physical, cognitive, social, and emotional development. The first scenario meets the periodicity schedule for well-child care set out in *Bright Futures* and checks off specific required medical examination boxes, but the second scenario embodies the overall *Bright Futures* guidelines for well-child care, including its emphasis on identifying and responding to social as well as bio-medical determinants of health.

Operating a practice that provides well-child visits that conform to scenario two has greater costs than visits that reflect scenario one. At heart, “value-based payment” systems are intended to provide differential payments that recognize these different values. If the current well-child visit as provided in scenario one is reimbursed \$75 (the typical payment by Medicaid, although subject to very large variations across states), it is easy to argue that scenario two has a value of double or triple that and should be reimbursed accordingly. It may be possible for a practice to maintain itself doing well-child visits with a reimbursement of \$75 for scenario one for its Medicaid patients, but certainly not for scenario two. If practices are to be incented to adopt scenario two, their reimbursement must be substantially greater.

This is true whether operating within a fee-for-service or a managed care environment. In most instances, the actual Medicaid reimbursement is similar under managed care payments and under fee-for-service ones (see part five for a detailed discussion of opportunities to reimburse high performing medical homes under different payment systems and models).

In addition to providing reimbursement for the office visit, Medicaid also may provide separate reimbursement for screens that are performed. Currently those primarily involve child-specific screens (e.g., Ages and Stages, autism screens) but also have extended in some instances to screens related to the family

Table 4. Measuring High Performing Pediatric Medical Homes for Young Children in Medicaid

High rates of access to care*
High percentage of children receiving well-child visits*
High rates of children who are up-to-date on immunizations*
High performance on developmental screening measure*
Satisfaction with the experience of care as measured with the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H*
Use of validated CSCHN screening tool
Use of SDOH screening tool, including maternal depression
Low rates of unnecessary emergency department visits*
Family engagement demonstrated through use of recommended Bright Futures pre-visit tools and/or the electronic Well-Visit Planner
Documentation on rates of referrals, follow up and completed referrals
Documentation of augmented resources and supports provided in practice (e.g., integrated mental health, Healthy Steps, Project DULCE, Reach Out and Read)
* Measures are part of CMS Medicaid-CHIP Core Child Set.

environment (e.g. maternal depression, ACEs, and screens around material and social risks). Again, states vary widely in the degree to which they enable practices to bill separately for screens, particularly screens for broader social determinants as opposed to child-specific behavioral and developmental screens, and what they pay for it. The greater the payment practices receive for both the practitioner's visit and screens that are conducted, the more the office can be structured to operate in the manner described in scenario two. Current payment rates for such office visits vary substantially across states (see Appendix E for description of variations across states both in office reimbursement and for screening). States need to look at what services they can reasonably expect practices to provide under current rates and what reimbursements will be needed to structure the office to practice as a high performing medical home.

It is important that financing systems distinguish between services provided by enhanced, high performing medical homes and regular well-child visits.

In developing differential payments for high performing medical homes, it is important that the financing system distinguish between this enhanced, high performing medical home and regular well-child visits. Making such distinctions requires the development of metrics and measures, which may include measures incorporated into electronic medical records but also other measures based on chart reviews or assessments of office organization and practice. Increasing the use of metrics and developing monitoring and measurement systems will help to ensure payment accountability and assist in quality improvement.

Beyond improving rates of use of well-child EPSDT visits and screens, states also need to develop measurement systems for high-quality well-child visits in the context of a high performing medical home. Table 4 shows measures that reflect key characteristics of high performing medical homes for young children in Medicaid.

References

- 1 Houtrow AJ, Larson K, Olson LM, Newacheck PW, Halfon N. Changing trends of childhood disability, 2001–2011. *Pediatrics*. 2014 Sep;134(3):530-538.
- 2 Halfon N, Larson K, Lu M, Tullis E, Russ S. Lifecourse health development: past, present and future. *Maternal and Child Health Journal*. 2014 Feb;18(2):344-65
- 3 Koh HK, Oppenheimer SC, Massin-Short SB, et al. Translating research evidence into practice to reduce health disparities: a social determinants approach. *American Journal of Public Health*. 2010 Apr;100(S1):S72-80.
- 4 Bruner C, Dworkin PH, Fine A, et al. Transforming young child primary health care practice: Building upon evidence and innovation. Child and Family Policy Center. 2006. Available at: https://www.cfpciowa.org/documents/filelibrary/issues/health_equity/Kitchen-CabinetPolicyStatement_July_DFB439EA1E807.pdf. Accessed September 7, 2018.
- 5 Child and Family Policy Center. Ten things you should know about health equity and young children. Available at: https://www.cfpciowa.org/en/issues/health_equity/. Accessed June 18, 2018.
- 6 Hagan JF, Shaw JS, Duncan PM, eds. Bright Futures: Guidelines for health supervision of infants, children, and adolescents, 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017. Available at: <https://brightfutures.aap.org/Pages/default.aspx>. Accessed June 18, 2019.

- 7 American Academy of Pediatrics Committee on Practice and Ambulatory Medicine, and Bright Futures Periodicity Schedule Workgroup. 2017 Recommendations for Preventive Pediatric Health Care. *Pediatrics*. 2017 Apr;139(4). Available at: <http://pediatrics.aappublications.org/content/pediatrics/139/4/e20170254.full.pdf>. Accessed August 30, 2018.
- 8 American Academy of Pediatrics. Bright Futures Medical Screening Reference Tables. Available at: <https://brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/Medical-Screening-Reference-Tables.aspx>. Accessed June 18, 2019.
- 9 U.S. Department of Health and Human Services. Health Resources and Services Administration. Bright Futures. Available at: <https://www.healthcare.gov/preventive-care-children/>. Accessed August 30, 2018.
- 10 U.S. Department of Health and Human Services. Preventive care benefits for children. Available at: <https://www.healthcare.gov/preventive-care-children/>. Accessed August 30, 2018.
- 11 American Academy of Pediatrics, American Academy of Family Practice, American College of Physicians and American Osteopathic Association. Joint Principles of the Patient-Centered Medical Home. 2007. Available at: https://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf. Accessed June 18, 2018.
- 12 Patient-Centered Primary Care Collaborative. Health care leaders to use new national criteria for patient-centered medical home. National Committee for Quality Assurance. 2007.
- 13 Patient-Centered Primary Care Collaborative. Available at: <https://www.pcpcc.org/about/shared-principles>. Accessed June 18, 2018.
- 14 Brown CM, Perkins J, Blust A, Kahn RS. A neighborhood-based approach to population health in the pediatric medical home. *Journal of Community Health*. 2015 Feb;40(1):1-11.
- 15 Coker TR, Chacon S, Elliott MN, et al. A parent coach model for well-child care among low-income children: A randomized controlled trial. *Pediatrics*. 2016 Mar;137(3):e2015-3013.
- 16 Sege R, Linkenbach J. Essentials for childhood: promoting healthy outcomes from positive experiences. *Pediatrics*. 2014;133(6):e1489-e1491.
- 17 Fierman AH, Beck AF, Chung EK, et al. Redesigning health care practices to address childhood poverty. *Academic Pediatrics*. 2016 Apr;16(3)(suppl):S136-S146.
- 18 Brown CM, Perkins J, Blust A, Kahn RS. A neighborhood-based approach to population health in the pediatric medical home. *Journal of Community Health*. 2015 Feb;40(1):1-11.
- 19 Samaan ZM, Brown CM, Morehous J, et al. Implementation of a preventive services bundle in academic pediatric primary care centers. *Pediatrics*. 2016 Mar;137(3):e20143136.



K. Johnson and C. Bruner. A Sourcebook on Medicaid's Role in Early Childhood: Advancing High Performing Medical Homes and Improving Lifelong Health. Child and Family Policy Center. October 2018.

Part Three

High Performing Medical Homes: Care Coordination and Case Management

Part Three / Key Takeaway Messages

- The terms “care coordination” and “case management” are both used, often interchangeably, to describe a range of activities that better link children and families to services and supports, promote access, address needs, and ensure follow up. A basic level of care coordination/case management for all patients is a defined part of the medical home.
- The definition of a medical home includes basic, routine care coordination. When a child has an identified physical, developmental, mental, or other condition, additional care coordination/case management may be needed. Similarly, when the child is in a family experiencing social risks and conditions (e.g. social determinants of health) that threaten the child’s health and development, more intensive care coordination may be essential. A high performing medical home in Medicaid must provide care coordination capable of responding to both bio-medical and social risks and conditions.
- Under EPSDT, children are entitled to case management coverage. Medicaid regulations specify a case management benefit, but do not define “care coordination.” States also can use the targeted case management (TCM) benefit under Medicaid, with flexibility to offer certain services to individuals in defined groups (such as young children), specific geographic areas, and delivered by qualified providers. Federal regulations define the following four categories of activity: 1) assessment, 2) development, 3) referrals and relative activities, and 4) monitoring and follow-up. In addition, states can pay for an array of care coordination activities in primary care settings or in the community apart from the case management benefit.
- Medicaid case management benefit categories can be used to cover this more intensive care coordination. States are financing care coordination under the case management or targeted case management benefit categories. Operationally, financing may be through direct reimbursement on a fee-for-services basis, on a capitated basis (e.g., per member, per month-PMPM, payment), or through incentives or bonuses for performance. Whatever the finance mechanisms, as described in Medicaid regulations, reimbursement should include direct time with the child and family and other time involved in gathering information, developing or updating the care plan, following up with families, scheduling appointments for referrals, and checking in with families and monitoring the care plan are covered services.

Defining Care Coordination and Case Management

The terms “care coordination” and “case management” are both used, often interchangeably, to describe a set of activities in child and family health used to promote optimal access to a range of services and supports.^{1 2} Even though the AAP, MCHB, and other child health leaders generally use the term care coordination,^{3 4 5 6} Medicaid traditionally finances coordination under the case management benefit. In research and practice, the terms care coordination and case management describe a range of activities that better link children and families to services and supports, promote access, ensure follow up, and address needs. One type of care coordination/case management is for those with health conditions within the “normal range,” which is designed to reduce barriers related to language, health literacy, culture, geographic access, and economic and social environments. For children with special health care needs, care coordination provides additional help navigating the broader health care system and communicating with multiple providers.⁷ For some families, a combination of medical and social needs calls for more intensive case management.⁸

Research has shown that care coordination/case management is associated with whether or not a child receives the care they need for physical, mental, and developmental conditions.^{9 10} Studies have shown that when a problem is suspected (or even diagnosed and services prescribed), young children often fall into the gaps in receiving services and coordinating care across different health care providers and systems, including mental health, child development, and early childhood education.¹¹ Moreover, care coordination/case management often represents a key strategy within managed care for select populations because it can lead to more appropriate service utilization and reduced costs, including better management of existing health conditions and reduced episodes requiring high-cost medical interventions.

A basic level of care coordination/case management for all patients is expected from the child health practitioner and office as part of being a medical home, particularly in referring to and following up with subspecialty services.¹² Pediatric medical home care coordination is a patient and family-centered, assessment-driven, team-based activity designed to meet the needs of children and strengthen families.

The AAP Finance Committee recommends that medical homes be financed sufficiently to include basic case management/care coordination, patient/family education, counseling, and related community coordination services. Payment sufficient to cover the cost of this basic care coordination is essential for ensuring the quality of the medical home.¹³ Of course, many families already serve the function of coordinating a whole range of care for their children, including medical care (and dental care) but extending to child care and other child activities. For many families, the primary child health practitioner merely needs to check-in with the parents to make sure the child's basic needs (including safety, supervision, and nurturing) are being met and care is coordinated. Often brief and routine care coordination can be done by telephone. As described in part two, the well-child visit and general office practice perform this general care coordination function for all children within a medical home.

Pediatric medical home care coordination is a patient and family-centered, assessment-driven, team-based activity designed to meet the needs of children and strengthen families.

When a child has an identified (i.e., diagnosed) behavioral, cognitive, developmental, or physical condition — often categorized as “special health care needs” — additional care coordination/case management may be needed as the medical home provider likely is making referrals to specialty and related services. Having dedicated staff time or community-based care coordination resources supports more efficient, effective, and completed referrals and helps to ensure that there is a team-based approach to providing services that is integrated and responsive to child and family needs.¹⁴ Care coordination addresses inter-related medical, social, developmental, behavioral, educational and financial needs in order to achieve optimal health outcomes. Key activities include creating care plans, monitoring plan actions, and sharing timely information among all members of the care team, including the patient and their family. However, the child may have family and social risks and conditions (i.e., social determinants of health) that threaten her health and development, even if these have not yet manifested in adverse health conditions, illness, or disability. EPSDT is designed to prevent such conditions from worsening. As shown in Figure 11, in part four of this sourcebook, these risks and conditions may be related to: the physical and material home environment, the physical and mental health status of the parents, the family's social ties and connections, and the parent-child relationship. Case management/care coordination is particularly important when the risks need to be addressed by providers and programs beyond the medical care system, as they require knowledge and skills that extend beyond what can be expected from (or is a good use of the expertise of) the primary care practitioner.

Case management and care coordination in Medicaid

Under EPSDT, children are entitled to case management coverage. Medicaid regulations specify a case management benefit, but do not define “care coordination.” However, many Medicaid agencies now refer to services covered under the case management benefit categories as “care management,” “service coordination,” “care coordination” or some other term related to planning and coordinating access to health care and other services on behalf of an individual.¹⁵ In Medicaid law, case management is a covered service in Section 1905(a) that has a meaning very similar to care coordination, and is defined as follows.

“Case management services means services furnished to assist individuals eligible under the State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, education, and other services in accordance with 42 CFR §441.18.” (42 CFR §440.169(a)).

At their option, states also can use the targeted case management (TCM) benefit (also known as medical assistance case management). Under TCM, states have the flexibility to offer certain services to individuals in defined groups, specific geographic areas and /or delivered by qualified providers. States submit

Case management/care coordination is particularly important when the risks need to be addressed by providers and programs beyond the medical care system

a state plan amendment to CMS in order to get approval for specific uses of TCM. For example, some states use TCM as the benefit category to finance select home visiting models for pregnant women and young children; others use TCM to provide specific styles of care coordination for children with special needs, developmental disabilities, or mental health conditions. A targeted case management benefit could be established specifically for very young children in households where the identified need for such case management was to strengthen the safety, stability, and nurturing in the home environment to improve the child’s healthy development.

Federal regulations define case management services to include the following four categories of activity and explicitly exclude direct delivery of medical, educational, social, or other services to which the individual has been referred.

1. Assessment (and periodic reassessment) to determine the need for any medical, educational, social, or other services, which includes taking client history, conducting structured assessment, and collecting other information;
2. Development (and periodic revision) of a care plan based on the information collected through the assessment, with specific goals and actions;
3. Referrals and related activities to help individuals obtain needed services, which include activities that help link the eligible individual with medical, social, educational providers, or other programs and services that are capable of providing needed services (e.g., making referrals to providers for needed services and scheduling appointments for the individual); and
4. Monitoring and follow up activities needed to ensure that the care plan is effectively implemented, which includes contacts with the individual, their family, and other providers as necessary and appropriate. (42 CFR Section 440.169(b)).

Other provisions in Medicaid cover “primary care case management services” and coordination of services in a “health home” program for people with chronic conditions. In addition, states have the flexibility to pay for an array of care coordination activities in primary care settings or in the community. These might be structured under existing authority, under waivers, or through managed care or accountable care arrangements. Billing codes exist for care coordination, as well as complex chronic care coordination, medical team conferences, and other approaches.

CMS recommends that state Medicaid agencies: build care coordination into standards for medical homes, support primary care providers by financing community-based care coordination entities (e.g., community health teams), put care coordination requirements into contracts with managed care organizations, and use strategies and tools to support care coordination.¹⁶ Federal regulations require that Medicaid managed care entities provide care coordination for each enrollee (42 CFR §438.208). State contracts can define performance expectations to strengthen care coordination, with a strong state performance monitoring approach to ensure compliance with the contract. CMS also recommends that states adopt quality measures for care coordination.

Beyond Basic Care Coordination: Key Attributes of Effective Practice

The definition of a medical home includes basic, routine care coordination, yet some children and their families need more intensive care coordination. Intensive care coordination involves skills and knowledge, particularly about community resources, that are different from the professional skills and training of the primary child health practitioner. In pediatric primary care practices with a high proportion of families who need more intensive care coordination, dedicated time from care coordination staff is essential, whether based inside the practice or in the community. Within a high performing medical home in Medicaid, there should be care coordination capable of responding to both bio-medical and social risks and conditions. Further, the frequency and intensity of that care coordination should reflect the complexity of the child’s condition and the family circumstances surrounding the child.

A growing number of practices provide care coordination that focuses on both bio-medical and social determinants, many specifically integrated into primary practice settings. Even though the specific processes and protocols surrounding care coordination vary, the exemplary practices in the Child and Family Policy Center’s Health Equity and Young Children initiative identified a set of common activities. These are in alignment with Medicaid rules and are intended to:

- Assess, screen, and monitor child and family needs, risks, and strengths;

Core attributes of effective care coordination

The Health Equity and Young Children Initiative charted some of the core attributes of effective care coordination, with implications to the recruitment, training, and stature within the medical home key to their effectiveness. Exemplary programs and practices reported the following:

- Immediacy and seamlessness of response,
- Concerted and persistent engagement of families,
- Emphasis on fostering family capacity, strengths, and resiliency,
- Recognition as a partner on the care team,
- Engagement and collaboration with other partners and agencies,
- Continuous learning and improvement, and
- Flexibility, humor, humility, and self-care.

- Help families identify priorities and set goals through a process that includes assessment of needs, engagement, and often a written plan;
- Provide and support completion of external referrals for families as needed (with warm hand off, warm transfer when possible, and generally moving beyond referral to scheduling and follow-up);
- Team with others, particularly within the practice/clinic, to ensure coordination and alignment of responses and to effectively bridge language, culture, and community differences; and
- Engage in ongoing coaching that builds parents' agency and capacity to serve as the child's care coordinator and advocate with other services and supports.¹⁷

It is clear that more intensive case management involves additional personnel, requires staff with skills in engaging families, and takes more time than the typical 15-20 minutes for child health visits.

What is clear, based on descriptions and reports regarding more intensive case management, is that it involves additional personnel beyond the primary care practitioner, uses staff with skills in engaging families, and involves time beyond the typical 15-20 minutes for child health visits. The skills needed by care coordinators in doing this work include relational and problem-solving skills with families, the practice itself, and other providers of services.

Medicaid also can pay for services delivered under evidence-based programs that emphasize care coordination, particularly those designed to be embedded in or to support pediatric primary care. Some address household material concerns (e.g., medical-legal partnerships), while others focus more on social support and health care navigation (sometimes including care coordinators with some “lived experience” such as community health workers and family advocates). Some provide direct hand-offs in the office at the time of a well-child visit, and others provide telephone care coordination for practices generally. Some larger health practices, including federally qualified health centers, have a social worker, child development specialist, and/or community health worker on staff that can be connected with the family during a well-child visit to follow-up with care coordination. Some communities have organized systems of referral and care coordination.¹⁸ Consider the following examples.

- The Help Me Grow program helps states and communities leverage existing resources, identify vulnerable children, link families to community-based services, and empower families to support their children's healthy development. This approach has been shown to be highly effective in connecting families with concerns about their children's development and behavior to appropriate, community-based programs and services. Help Me Grow generally involves practitioners referring families to care coordinators who in turn provide their care coordination through a call center. Families are then matched with services and supports, including scheduling appointments. Help Me Grow also provides child health providers with cost-effective alternatives to unnecessary and expensive medical specialty referrals, thereby preserving the capacity of specialists for those children who need it most. Currently operating in 28 states, Help Me Grow uses a mix of public and private funding.
- An intervention called Parent-focused Redesign for Encounters, Newborns to Toddlers (PARENT) provided a non-physician “coach” to provide more guidance, screening, and support to low-income families. Compared with the control group, families were significantly more likely to receive preventive services, developmental screening, guidance, health information, and psychosocial assessments

for family risks. Parents found the care more helpful and were more likely to have their developmental and behavioral concerns addressed.¹⁹

- Child First is an evidence-based model providing intensive, home-based services for high-risk families, using direct psycho-therapeutic intervention and care coordination. It is designed to serve families with multiple challenges and trauma (e.g., maternal depression, domestic violence, child maltreatment, substance use). The Child First care coordinators work with the mental health clinician and facilitate access to family-driven, comprehensive, well-coordinated, individualized services and supports throughout the community. The care coordinator coaches, guides, and supports parents in actualizing the plan. They also foster cross-system relationships with other local agencies and providers. Research shows significant improvements in families having service needs met.^{20 21}

Table 5. Financing Case Management and Care Coordination

Core function for high-performing pediatric medical home	Medicaid mechanism	Reimbursement and fiscal sustainability	Quality and value measures for incentives and accountability
Well-Child Visit and Prevention Practices	[See Part Two]	[See Part Two]	[See Part Two]
<p>Case Management/Care Coordination</p> <ul style="list-style-type: none"> • May occur at low, moderate, and more intensive levels, with tiered payments based on intensity. • At low level, role of the pediatric medical home to provide care coordination, follow up, and referrals. • At more intensive level, engagement and whole-child/family approach to identify needs and opportunities (through motivational interviewing, appreciative inquiry, and other tools that also promote family self-sufficiency and efficacy) • Referral and connection of families to services and supports to address medical conditions and risks, as well as social determinants of health (scheduling and follow-up) 	<ul style="list-style-type: none"> • Case management (most often) or targeted case management benefit. • Payment on fee-for-service, capitated (e.g., per member per month), or incentive/bonus payments for performance. • Payment structured to finance staff time within practice (e.g. community health worker, CSHCN care manager) or community-based programs providing more intensive care coordination. 	<p>Reimbursement that covers the cost related to the staff performing the case management, including the time involved with the child and family and the time identifying and securing referrals and doing the follow-up. For example:</p> <ul style="list-style-type: none"> • For case management provided as a unit of service, this might be \$50 to \$75 per child contact or visit (including assessment, development of plan, referrals, and follow up). • For case management provided under a capitated system, this might be \$10 to \$20 per month based per qualifying child. • For community-based programs, this might be a unit of service payment of \$25 to \$50 per hour of contact or a bundled service for six months involvement of \$100 to \$200. 	<ul style="list-style-type: none"> • Care plans for children and families with higher needs and risks identified, including assessment of more specific needs and specification of actions for families beyond initial screen and referral • Follow-up report to practice and securing of additional pediatric referrals to other needed Medicaid-covered services • Documentation of successful referrals • Measures for and objective measurement of family experience and family engagement (e.g., CAHPS, Promoting Healthy

Approaches to Financing for Care Coordination

Medicaid case management benefit categories can be used to cover this more intensive care coordination. States are financing care coordination under the case management or targeted case management benefit categories, with the former often related to EPSDT requirements. As reported by the National Academy for State Health Policy, states have used a variety of administrative mechanisms to finance case management/care coordination for young children in Medicaid.²² For example, some states:

- provide a monthly case management fee
- offer payment incentives to practices that demonstrate higher performance in medical home
- emphasize case management in managed care contracts
- use the health home option for persons with chronic conditions
- engage health departments in case management/care coordination
- cover perinatal case management for pregnant women and infants
- develop specific protocols for referrals from primary care to early intervention

The cost of staff time for more intensive care coordination can be substantial and needs to be reimbursed above basic primary care services. Operationally, financing may be through direct reimbursement on a fee-for-services basis, on a capitated basis (e.g., per member, per month-PMPM), or through incentives or bonuses for performance. In any case, the financing may be on a unit-of-service basis (generally related to the time directly spent with the child and family) or as a bundled payment (generally over a longer period). Under either approach, as described in Medicaid regulations, the costs of both direct time with the child and family and indirect time — gathering information, developing or updating the care plan, following up with families, scheduling appointments for referrals, and checking in with families and monitoring the care plan — are covered.

PMPM payments can provide a predictable revenue stream for practices so they can hire and support staff to provide care coordination, while reimbursement by unit of service or as a bundled service may appear less predictable to a practice in recovering the cost of adding care coordination staffing. At the same time, PMPM payments might be set at a rate that limits the number of staff below the level of need, affecting the number of children and families that can be served.

Reimbursement rates should reflect what is needed to provide basic, moderate, and more intensive care coordination/case management. Tiered reimbursement levels with clear definitions can aid providers and managed care organizations in providing the right level of service, making efficient and effective use of available resources. Some states, like New Mexico, are using three levels of tiered case management in Medicaid managed care.

Table 5 is completed for the care coordination-case management role as it was for the well-child visit and office practice role in part two.

Identifying Child and Family Need for Care Coordination and Complexity of Needed Response

Some states use algorithms or criteria for medical complexity, developmental status, and/or psychosocial risk to determine the need for care coordination for their Medicaid populations, particularly related to identifying those with high medical costs. Use of the CSHCN screening tool is one validated, objective approach to assessing chronic conditions (physical, mental, functional).^{23 24 25 26} Even though algorithms and criteria for medical complexity have sometimes been used to identify children, states are only beginning to develop child-specific algorithms or criteria that extend beyond medical diagnoses.

Discussed further in this sourcebook (particularly in part four), pediatric primary care practices can screen for health-related, non-medical conditions that pose risks for healthy development, and tools are being developed that provide for screening of social determinants of health.²⁷ Such efforts can provide a basis for developing new algorithms and estimating both the number and proportion of young children who should receive more intensive coordination, given the range of services that may need to be accessed and coordinated.

Measuring the Impact of Care Coordination

As with well-child visits, states need to apply metrics and measures to ensure children and families who qualify for case management/care coordination are receiving it and that care coordination is producing effective referrals, meeting case plan goals, and increasing family agency in securing and using services. Over time, such metrics and measures also can help determine the degree to which care coordination is reaching its intended population and support continuous improvement in making effective referrals, as well as identifying areas of unmet need or duplicative or misaligned services. An important barrier to measuring the effectiveness of care coordination is discontinuous enrollment in Medicaid for children. If children frequently move on and off Medicaid — as they do in many states — measuring continuity of care coordination is particularly challenging.²⁸

Tiered reimbursement levels with clear definitions can aid providers and managed care organizations in providing the right level of service, making efficient and effective use of available resources.

In addition, some tools are available for measuring care coordination and family satisfaction. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) patient surveys assess patient experience and help improve the quality of care.²⁹ The CAHPS 5.0H Child Survey is part of the CMS core set of child health measures and includes supplemental questions related to family-centered care, coordination of care for children, and other aspects of family satisfaction with care.³⁰ The Care Coordination Tool developed at Boston Children's Hospital is another resource.³¹ In addition the Promoting Healthy Development Survey (PHDS) is endorsed by the National Quality Forum as a valid measure for system, plan, practice and provider-level assessment.³² The PHDS collects information on referrals and follow up as one domain. It has been used by Medicaid agencies,³³ health plans, pediatric practices, and the National Survey of Early Childhood Health (NSECH).³⁴

Part seven of this sourcebook discusses broader issues of measurement, including review of the CMS core set of child health measures and CAHPS.

References

- 1 Hanlon C. Measuring and improving care coordination: Lessons from ABCD. National Academy for State Health Policy, 2013. Available at: <http://nashp.org/measuring-and-improving-care-coordination-lessons-abcd-iii/>. Accessed June 23, 2018.
- 2 Johnson K, Rosenthal J. Improving care coordination, case management, and linkages to service for young children: Opportunities for states. National Academy for State Health Policy and Commonwealth Fund. 2009. Available at: <http://nashp.org/improving-care-coordination-case-management-and-linkages-service-young-children>. Accessed June 20, 2018.
- 3 Turchi RM, Berhane Z, Bethell C, et al. Care coordination for CSHCN: Associations with family-provider relations and family/child outcomes. *Pediatrics*. 2009 Dec 1;124(Supplement 4):428-434.
- 4 Antonelli RC, Antonelli DM. Providing a medical home: The cost of care coordination services in a community-based, general pediatric practice. *Pediatrics*. 2004 May 1;113(Supplement 4):1522-1528.
- 5 American Academy of Pediatrics (AAP), Committee on Children with Disabilities. Care coordination: Integrating health and related systems of care for children with special health care needs. *Pediatrics*. 1999;104(4 Pt.1):978-981.
- 6 American Academy of Pediatrics (AAP). Care Coordination in the Medical Home: Integrating health and related systems of care for children with special health care needs. *Pediatrics*. 2005;116(5):1238-1244.
- 7 American Academy of Pediatrics. Care Coordination in the Medical Home: Integrating Health and Related Systems of Care for Children with Special Health Care Needs. *Pediatrics*. 2005;116(5):1238-1244.
- 8 Bruner C. Developing an outcome evaluation framework for use by family support programs. In: Family support as reflective practice. Dolan P, Canavan J, Pinkerto, J. (Eds.) Jessica Kingsley Publishers. 2006. Pp. 237-249.
- 9 Beck AF, Tschudy MM, Coker TR, et al. Determinants of health and pediatric primary care practices. *Pediatrics*. 2016;137(3):e2015-3673.
- 10 Van Cleave J, Boudreau AA, McAllister J, et al. Care coordination over time in medical homes for children with special health care needs. *Pediatrics*. 2015;135(6):1018-1026.
- 11 Miller K. Care coordination impacts on access to care for children with special health care needs enrolled in Medicaid and CHIP. *Maternal and Child Health Journal*. 2014;18(4):864-872.
- 12 McAllister JW, Presler E, Cooley WC. Practice-based care coordination: A medical home essential. *Pediatrics*. 2007 Sep;120(3):e723-733.
- 13 Hudak ML, Helm ME, White PH, Committee On Child Health Financing. Principles of child health care financing. *Pediatrics*. 2017 Jul 17:e2017-2098.
- 14 Goyal NK, Hall ES, Kahn RS, et al. Care coordination associated with improved timing of newborn primary care visits. *Maternal and Child Health Journal*. 2016 Sep;20(9):1923-1932.
- 15 Centers for Medicare and Medicaid Services (CMS). Medicaid program; Optional state plan case management services. Federal Register. 2007 Dec 4;72(232):68077-68093. Available at: <https://www.gpo.gov/fdsys/pkg/FR-2007-12-04/pdf/07-5903.pdf>. Accessed July 23, 2018.
- 16 Centers for Medicare and Medicaid Services. Making Connections: Strengthening care coordination in the Medicaid benefit for children and adolescents. 2014. Available at: <https://www.medicaid.gov/medicaid/benefits/epsdt/index.html>. Accessed June 20, 2018.
- 17 Bruner C, Cardenas A. Bruner C, Cardenas A. Lessons from exemplary programs: Strategies to promote healthy development in young children. Child and Family Policy Center. 2018. Available at: https://www.cfpciowa.org/documents/filelibrary/issues/health_equity/LessonsFromExempProgFINALSept_18_ABF7D8251642D.pdf. Accessed September 10, 2018
- 18 Silow-Carroll S, Heglow G. Systems of care coordination for children: Lessons learned across state models. Commonwealth Fund. 2010.
- 19 Coker TR, Chacon S, Elliott MN, et al. A parent coach model for well-child care among low-income children: A randomized controlled trial. *Pediatrics*. 2016;137(3):e2015-3013.
- 20 Child First. Available at: www.childfirst.org. Accessed July 13, 2018.
- 21 Lowell DI, Carter AS, Godoy L, et al. A randomized controlled trial for Child FIRST: A comprehensive home-based intervention translating research into early childhood practice. *Child Development*. 2011;82(1):193-208.
- 22 National Academy for State Health Policy. EPSDT Toolkit: Care Coordination. Available at: <https://nashp.org/care-coordination/>. Accessed July 12, 2018.
- 23 Child and Adolescent Health Measurement Initiative. Children with Special Health Care Needs Screener. Available at: <http://www.cahmi.org/projects/children-with-special-health-care-needs-screener/>. Accessed July 13, 2018.
- 24 Bethell CD, Read D, Blumberg SJ, et al. Identifying children with special health care needs: Evaluation of a short screening instrument. *Ambulatory Pediatrics*. 2002;2:38-48.
- 25 Berry SS, Soltau E, Richmond NE, et al. Care coordination in a medical home in post-Katrina New Orleans: Lessons learned. *Maternal*

and Child Health Journal. 2011;15:782-793.

- 26 Bethell CD, Blumberg SJ, Stein REK, et al. Taking stock of the CSHCN Screener: A review of common questions and current reflections. *Academic Pediatrics*. 2015;15(2):165-176.
- 27 Bruner C, Johnson K, Bethell C, et al. Next steps in family-focused screening to address social determinants of health for young children in primary care. Report of the Social Determinants of Health Technical Working Group of the Maternal and Child Health Measurement Research Network. Child and Adolescent Health Measurement Initiative, Johns Hopkins Bloomberg School of Public Health. August 2018.
- 28 Weier RC, Gardner W, Conkol K, Pajer K, Kelleher KJ. Partners for Kids care coordination: Lessons from the field. *Pediatrics*. 2017 May;139(Suppl 2):S109-S116.
- 29 Agency for Healthcare Research and Quality. The CAHPS Program. Available at: <https://www.ahrq.gov/cahps/about-cahps/index.html>. Accessed July 13, 2018.
- 30 Centers for Medicare and Medicaid Services. Guidance for Conducting the Consumer Assessment of Healthcare Providers and Systems (CAHPS) 5.0H Child Survey. Technical Assistance Brief. December, 2012. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/cahpsbrief.pdf>. Accessed July 12, 2018.
- 31 Bethell C, Reuland C, Schor E. Assessing health system provision of well-child care: The Promoting Healthy Development Survey. *Pediatrics*. 2001 May; 107(5):1084-1094.
- 32 Bethell C, Reuland C, Schor E. Assessing health system provision of well-child care: The Promoting Healthy Development Survey. *Pediatrics*. 2001 May; 107(5):1084-1094.
- 33 Bethell C, Peck C, Abrams M, et al. Partnering with Parents to Promote the Healthy Development of Young Children Enrolled in Medicaid. Commonwealth Fund. September 2002. Available at: http://www.commonwealthfund.org/sites/default/files/documents/media_files_publications_fund_report_2002_sep_partnering_with_parents_to_promote_the_healthy_development_of_young_children_enrolled_in_medicaid_bethell_partnering_570_pdf.pdf. Accessed July 12, 2018.
- 34 Bethell, C, Reuland C, Halfon N, Schor EL. Measuring the quality of preventive and developmental services for young children: National estimates and patterns of clinicians' performance. *Pediatrics*. 2004 Jun;113(6 Suppl):1973-1983.



K. Johnson and C. Bruner. A Sourcebook on Medicaid's Role in Early Childhood: Advancing High Performing Medical Homes and Improving Lifelong Health. Child and Family Policy Center. October 2018.

Part Four

Screening in High Performing Medical Homes: Development, Health, and Well-being

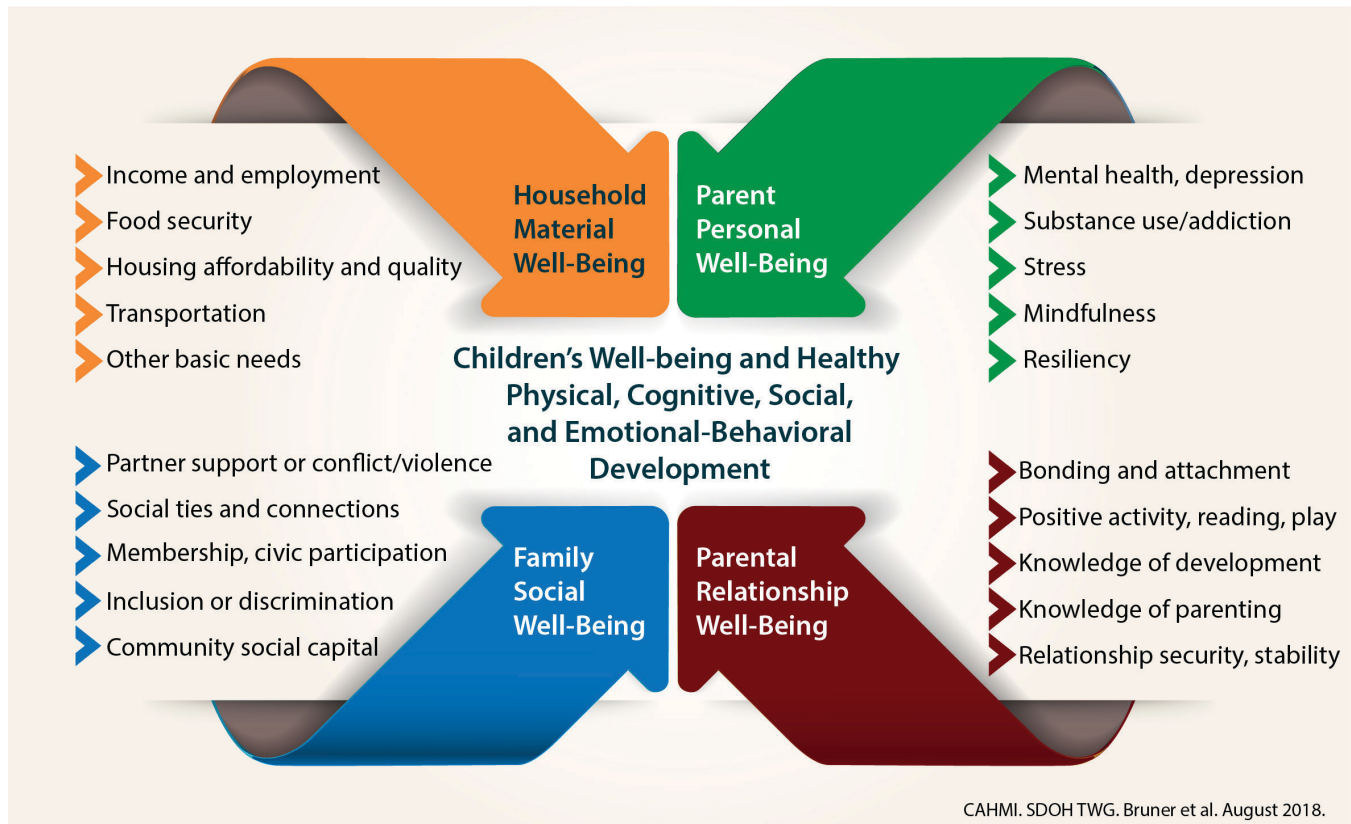
Part Four / Key Takeaway Messages

- Practice in the high performing medical home should extend beyond traditional screening for general development in young children to include screening for social determinants of health. This is essential for identifying and responding to social determinants of health and related early childhood risks, with emphasis on affecting health trajectories over the life course, not just addressing immediate health conditions.
- Medicaid's EPSDT benefit requires developmental screening. *Bright Futures* guidelines recommend that developmental screening tests for young children be administered during the well-child visits at 9, 18, and 30 months. These visits are reflected in the AAP periodicity schedule for preventive well-child visits and in some, but not all, state EPSDT schedules. States have opportunities to improve the financing of these services, as well as the use of validated screening tools and measurement of practice, health plan, and state-level performance.
- The Medicaid/CHIP Child Core Measurement Set includes a measure called "Developmental Screening in the First Three Years of Life." The measure can be used to monitor how Medicaid providers, managed care plans, and state programs overall are performing in terms of developmental screening of young children. Not all states have yet adopted this measure.
- Screening for social-emotional development increasingly is used in pediatric primary care for young children. Screening for social-emotional/behavioral/mental health is part of the EPSDT benefit. Now more than ever, providers are offering and Medicaid is financing social-emotional-behavioral screening designed specifically for young children and some also are conducting maternal depression screening (one core social determinant of health for young children) as part of well-child visits.
- Screening for social determinants of health is an emerging area, with new tools, practice approaches, and financing opportunities. Responding to SDOH risks and needs identified through screening requires discussions between health providers and families, as well as referrals and follow up.

Screening as a Core Part of a High Performing Medical Home

As part of a high performing medical home and during a well-child (or other) visit, the primary child health practitioner follows a protocol for assessing the child's health and development and also engages in "surveillance," a technique designed to identify other issues and concerns that may not be part of the established protocol. Beyond general surveillance, the well-child visit can include specific screening related to the child's health and development or to conditions around the child affecting that development. As part two describes, these activities can be billed separately, and adequate reimbursement is needed to sustain the practice in both conducting and using the screens. In terms of content, this includes screenings related to both the child's development and well-being (including developmental and social and emotional well-being) and screening related to conditions around the child (social determinants of health) that affect healthy development. This section discusses screening in the context of a high performing medical home for both developmental and social determinant concerns.

Figure 13. Social Determinants of Health and Well-Being Affecting Healthy Child Development



Addressing the Roots of Health and Well-being in a High Performing Medical Home

Research shows that young children's health and development has impact throughout the life course, affecting child and adult health and well-being.^{1 2 3 4 5 6 7 8} As scientific knowledge has expanded, and advances have been made in medical care, a broader conception of health and the role of health practitioners in advancing health has emerged. The term "health" has been redefined beyond clinical diagnoses and treatment or management of disease and disability. The term now recognizes that health is more than the absence of disease or disability and is about optimal health and well-being.⁹ Increasing focus has been placed on responding to social determinants of health and related early-childhood risks, with emphasis on affecting health trajectories over the life course, not just addressing immediate health conditions.^{10 11 12}

For young children, many of the social determinants of health apply directly to the parent or primary caregiver and the home environment, and indirectly to the child.

For young children, many of the social determinants of health apply directly to the parent or primary caregiver and the home environment, and indirectly to the child. During the first years of life, the safety, stability, and nurturing in the home environment is foundational to healthy child development — physical, cognitive, social, and emotional. When caregivers lack parenting skills or experience stress, depression, substance use, and social marginalization, such factors can have profound effects on children's health trajectories. The research on adverse childhood experiences and toxic stress shows that family tur-

moil during early childhood is particularly damaging to children’s development and over the life course can lead to subsequent preventable chronic medical conditions. They can also affect educational, social, and emotional conditions, including justice system involvement, employability and earnings, and roles in the community and as parents of the next generation.^{13 14 15 16}

In short, the objectives of health and health-related services for young children can and should be on improving the child’s health trajectories, but this cannot be achieved without a focus on the child’s family. This is in contrast to adults, where family plays a smaller role in determining an adult’s health. The schematic below suggests the special foci on families and the supports around the child that are needed for very young children. These require different metrics and practices than for adults. Child well-being is mediated through social determinants related to household economic well-being, parental personal well-being, family social well-being, and parent-child relationship well-being.

There are multiple definitions of these SDOH, with most focusing on non-medical factors related to policy, social context, material, and environmental factors.¹⁷ Drawing substantially from the initial definition and factors established by the World Health Organization,^{18 19} Bruner and others have developed a definition more specifically directed to young children, recognizing that the safety, stability, and nurturing in the family home environment is core to healthy development.²⁰ As shown in Figure 11, these can relate to the physical and material home environment, parental health, the family’s social supports and connections, and the parent-child relationship.

As discussed earlier in this sourcebook, children’s primary health care is undergoing a transition to increase focus on early development of health and well-being, which requires attention to social as well

Children’s primary health care is undergoing a transition to increase focus on early development of health and well-being, which requires attention to social as well as bio-medical determinants of health.

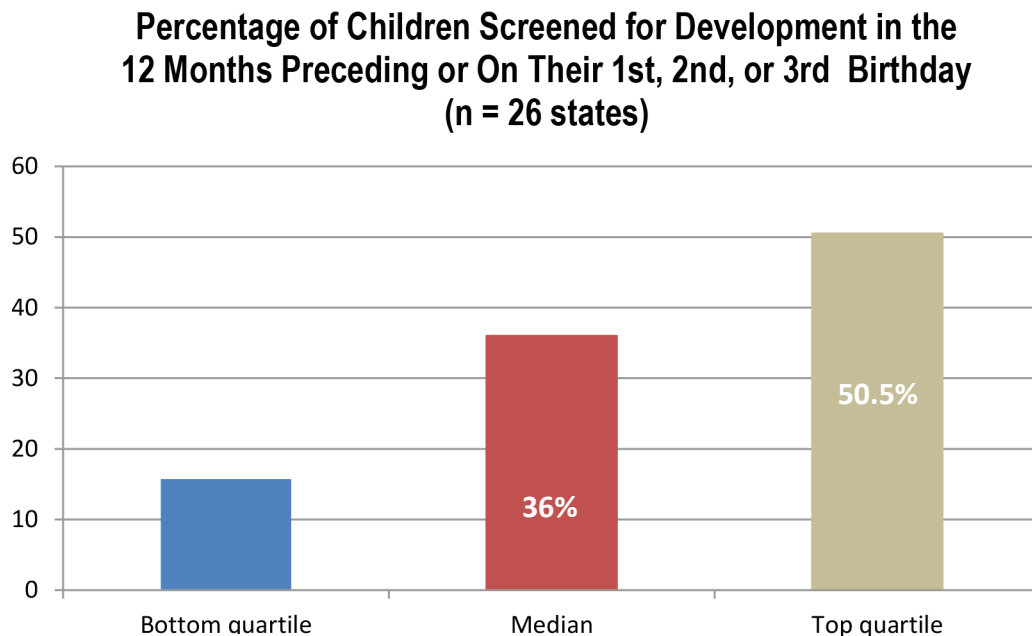
as bio-medical determinants of health. Innovators in child health have developed more ecological approaches to identifying and responding to young children in primary care, starting with broader approaches to screening that goes beyond specific child health risks and conditions to more fully engage families through supportive discussions and practice regarding factors influencing the whole well-being of children and families.^{21 22} Many approaches available for use in the pediatric primary care setting have yet to be widely adopted and could be advanced through Medicaid policy and financing.

Developmental Screening and EPSDT

Developmental screening at specified visits with objective screening tools, as well as ongoing developmental surveillance, is recommended by the AAP and other primary care provider organizations. The goal is to identify risks and possible delays in growth and development early and take follow up action to intervene. Conducting developmental screening is the role of primary health care providers and responding to identified risks is one of the key roles of a high performing medical home.

The federal Medicaid statute does not list “child development” as a benefit category, but these services are specifically covered under the EPSDT child health benefit. CMS affirms that developmental and behavioral health screenings are required for all Medicaid-enrolled children under EPSDT and are also covered for children in CHIP.

Figure 14. State Medicaid Performance on Developmental Screening



Source: Quality of Care for Children in Medicaid and CHIP: Findings from the 2016 Child Core Set Chart Pack. Page 32.

“Periodic developmental and behavioral screening during early childhood is essential to identify possible delays in growth and development, when steps to address deficits can be most effective. These screenings are required for children enrolled in Medicaid...” CMS²³

Comprehensive well-child visits through EPSDT include developmental screening based on professional guidelines and standards of care such as *Bright Futures*.²⁴ During early childhood, screening for physical and mental/behavioral health and other risks is essential to identify risks and possible delays in development. Developmental screening at specific times in early childhood, developmental surveillance at each well-child visit, and follow-up diagnosis and treatment are recommended for all children to ensure early intervention to correct or ameliorate conditions. Developmental screening is a covered service for children enrolled in Medicaid, including children enrolled in Medicaid expansion CHIP. CMS has identified resources to support states in ensuring Medicaid enrolled children receive developmental screening.²⁵

Bright Futures guidelines recommend that developmental screening tests be administered during the well-child visits at 9, 18, and 30 months. These visits are reflected in the AAP periodicity schedule for preventive well-child visits and in some, but not all, state schedules. Standards of practice and EPSDT federal rules call for screening of young children across six primary domains of development, including: 1) gross motor, 2) fine motor, 3) communication skills or language development, 4) self-help and self-care skills, 5) social-emotional development, and 6) cognitive skills.²⁶ In addition to screening for these categories of general development, state Medicaid programs are required to cover screening for vision, speech-language-hearing, and dental needs.

Even though no specific list of screening instruments is mandated, federal rules call for use of culturally sensitive and validated tools, and some states recommend specific tools. State agencies often identify a

set of standardized, objective screening tools recommended or required for use in Medicaid/CHIP. State Title V Maternal and Child Health programs and other child health professionals play an essential role in advancing evidence-based practice, recommending tools, and promoting widespread use of developmental screening.

Recommendations in pediatrics call for general developmental screening of young children; however, research suggests social-emotional development, in particular, is important as an initial indicator of general well-being versus risk.²⁷ Screening for social-emotional/behavioral/mental health is part of the EPSDT benefit. Increasingly, providers are offering — and Medicaid is financing — social-emotional-behavioral screenings designed specifically for young children, while also offering maternal depression screening as part of well-child visits.²⁸ For example, the combined efforts of a team of state leaders in Minnesota led to success in expanding use of screening for general development and social-emotional development.²⁹ Minnesota reviewed 15 commonly used tools and made recommendations to promote developmental screening.

One validated tool that has been widely used in health, early care and education, and other settings is the Ages and Stages Questionnaires: Social-Emotional (ASQ:SE). Studies of its use as a universal screening tool have been conducted.^{30 31} Additionally it has been used to assess the effect of integrated behavioral health (i.e., colocated psychologist) over time.³²

In line with *Bright Futures* recommendations, new tools to screen for social determinants of health are being used in a small, but growing number of pediatric primary practices. This involves asking about more than the child's health, behavior, and developmental status.

The Medicaid/CHIP Child Core Measurement Set, includes a measure called “Developmental Screening in the First Three Years of Life.” (See part seven for the full Child Core Set of measures.) This measure reports the percentage of children screened for risk of developmental, behavioral, or social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday. The measure can be used to monitor how Medicaid providers, managed care plans, and state programs overall

Federal rules call for use of culturally sensitive and validated screening tools, and state agencies often identify a set of standardized, objective tools recommended or required for use in Medicaid/CHIP.

are performing in terms of developmental screening of young children. It also can be used in quality improvement efforts to help providers and managed care organizations improve their performance. Not all states have yet adopted this measure since it was released in 2016. As shown in Figure 12, among the 26 states reporting data in FFY 2016, the average was 36 percent. In 2016, developmental screening rates for children under age 3 ranged from 1.6 percent in Alaska to 77.5 percent in Massachusetts.³³ These data point to opportunities for improved performance in every state.

Having billing codes and adequate reimbursement rates, combined with measurement and quality improvement efforts, can improve performance in terms of developmental screening. As reported by the National Academy for State Health Policy in 2016, many states now use distinct billing codes for developmental screening, but approximately 20 states do not recommend or require validated screening tools, and only six states set reimbursement above \$20 for screening (Arizona, California, Iowa, Hawaii, Kansas, and Kentucky).

A number of states have implemented initiatives to use legal, data, and quality improvement strategies to increase appropriate use of developmental screening in pediatric practices. State efforts in Iowa, North Carolina, Oregon, Texas, Vermont, and Washington have been widely recognized. For example, in North Carolina attention to and training for office processes resulted in a significant increase in screening rates to more than 70 percent of the designated well-child visits. This project led to a change in Medicaid policy, and screening in EPSDT well-child visits improved statewide.³⁴ In Washington, state legislation was enacted in 2015 that adopts the *Bright Futures* recommended schedule for developmental and autism screening as its standard for kids covered by Medicaid.³⁵

State have shown success in increasing developmental screening for young children enrolled in Medicaid. An increasing number are using a national measure to monitor performance.

When a developmental screen indicates a risk or condition, follow-up action to complete a fuller diagnostic assessment is a critical next step. For children enrolled in Medicaid, such diagnostic services are financed by Medicaid unless financed under the Individuals with Disabilities Education Act (IDEA) Part C Early Intervention Program for Infants and Toddlers³⁶ or Part B Special Education Program. In many states, Medicaid has developed partnerships with Part C and maternal and child/family health programs to maximize use of Medicaid and improve outcomes.³⁷ Medicaid financing is used by virtually all states to finance a portion of Part C Early Intervention services. Making referrals, service delivery, and payment practices efficient and effective helps to reduce cost and improve outcomes. Projects across the country have demonstrated ways to streamline administrative practices, achieve cost efficiencies, maximize available providers, and better serve families with young children, including partnerships with pediatric medical homes.³⁸

At the same time, states set different eligibility criteria for Part C, with many requiring very substantial developmental delays or disabilities to be eligible for services.³⁹ Nationally, only about 3 percent of all young children are receiving Part C services, although many more have some diagnosable delay. Screening and then referring to Part C does not fulfill the practitioner's responsibility to respond to developmental delays, although it can be an essential service to those who then qualify for assistance.

States have shown success in increasing developmental screening for young children enrolled in Medicaid. An increasing number of states are using a national measure to monitor performance. Taking action and financing interventions for identified risks and conditions is equally critical. Best practices used by states to focus on developmental screening in Medicaid include the following.

- Require use under EPSDT of the American Academy of Pediatrics *Bright Futures*-recommended periodicity schedule and guidelines for well-child visits.
- Recommend or require age-appropriate, validated screening tools (i.e., for general development, social-emotional development, and social determinants of health) in rule, provider manuals, and managed care contracts.
- Adopt the available billing codes and communicate them to plans and providers.
- Use the Medicaid/CHIP developmental screening measure. Require that providers and plans report using the measure and aggregate and report statewide data to CMS.

- Permit separate billing for screening (unbundle).
- Pay separately or at a higher reimbursement rate for enhanced pediatric primary care screening (e.g., social-emotional, maternal depression, SDOH, ACE), including screening delivered on the same day as well-child visit.
- Clarify that EPSDT interperiodic visits (as defined in federal law) are permitted for developmental screening when parents or other providers have concerns about development.
- Use performance incentives (financial and non-financial) for pediatric primary care providers and/or health plans to increase use of developmental screening, using the CMS measure to monitor performance.
- Set clear payment rules between Medicaid and IDEA Part C or Part B programs, and identify children enrolled in both Medicaid and IDEA Part C or Part B services to reduce prior authorization and related administrative burden.
- Use Medicaid to finance developmental services for children with identified risks who do not have delays or conditions severe enough to qualify for IDEA programs, in order to prevent worsening of conditions.
- Use Medicaid to support augmentation of pediatric practice staff capacity to support development and address identified risks, such as addition of care coordination staff, HealthySteps specialists, behavioral health staff, etc. (See part five of this sourcebook.)

Screening for Social Determinants of Health

Screening for SDOH in pediatric primary care and well-child visits is an emerging area of practice.^{40 41}

⁴² In fact, primary care practitioners are seeking ways to screen for SDOH across the lifespan.^{43 44 45 46 47}

⁴⁸ The use of an objective screening tool for SDOH is that it can better identify families who can benefit from attention to their home circumstances and help the practitioner initiate a discussion with and exploration of family concerns. Research shows practitioners often miss the most at-risk children and families when they rely only on their observations.⁴⁹

One dilemma is having appropriate, acceptable, objective, validated, and useful screening tools. Reviews of existing screening tools for all ages have been conducted.⁵⁰ Many questions or series of questions around particular factors (e.g., adequacy of housing, food sufficiency) have been validated as part of research studies; others have been put into practice without having studies of their reliability and validity. In the context of young children and their families, the validity of questions is important. It is equally important to use the process to promote educational, supportive, and problem-solving discussions between health providers and families — and to assist care coordinators in linking young children and their families to services that enhance healthy child development by responding to those social determinants.

As part of a Child and Adolescent Health Measurement Initiative Technical Working Group (TWG), Bruner conducted a review of the published and the grey literature using the four domains described above (material well-being, psychological well-being, social well-being, and relationship well-being). This yielded a broad set of questions, which were synthesized and formulated into a screening tool composed of 18 questions, designed for use in the first years of life. This composite screening⁵¹ tool covers the four domains, drawing as much as possible on validated screening questions and existing tools in practice and

an additional cross-walk between the screening questions in the tool and the different questions presented in *Bright Futures* guidelines.⁵²

Responding to SDOH risks and needs identified through screening requires discussions between health providers and families. Asking parents to respond to sensitive questions about themselves, without providing the opportunity to discuss them, can produce anxiety, shame, or the reliving of negative experiences (one of the reasons the TWG selected not to include questions regarding ACEs). Not asking about these topics that clearly impact health can also result in similar anxiety, shame and negative experiences.⁵³

⁵⁴ Select practices, including a number of Help Me Grow sites, have incorporated the Well-Visit Planner into their structure, by encouraging parents to complete that online tool prior to their well-child visit and share the results with the practitioner.

The Well-Visit Planner not only includes a number of screening questions, particularly around the child's development, but also offers immediate resources to parents regarding issues and suggests specific concerns to raise with the practitioner during the well-child visit. Research suggests the Well-Visit Planner benefits practitioners by making better use of well-visit time with the family; both the child and the family also benefit by understanding the child's needs and encouraging timely solutions to concerns.

An objective screening tool for social determinants of health can better identify families who can benefit from attention to their home circumstances and help the practitioner initiate discussion of family concerns.

As discussed in part three of this sourcebook, for an estimated 10 to 30 percent of families overall and half or more in certain poor and isolated communities,⁵⁵ follow up involves more than anticipatory guidance typically provided by the practitioner in the well-child visit. In some cases pediatric practices can provide interventions, but response to most SDOH will require a referral and follow up. Effective follow up entails a “warm handoff” from the health provider practice to a care coordinator, social worker, family advocate, resource navigator, or other individual — either within the office or through an outside resource.

Again, the screening tool is simply a starting point for referral and further discussion with a care coordinator; often, such a discussion results in identifying family goals, ideas, or positive actions that are not evident from or directly tied to the survey responses. When additional services are needed, families generally benefit from the support care coordination can provide when navigating multiple systems of care.

References

- 1 National Research Council and Institute of Medicine. From Neurons to Neighborhoods: The Science of Early Childhood Development. JP Shonkoff, DA Phillips (Eds.). National Academies Press. 2000.
- 2 National Academies of Sciences, Engineering, and Medicine. Parenting Matters: Supporting Parents of Children Ages 0-8. VL Gadsden, M Ford, H Breiner (Eds.). Washington, DC: National Academies Press. 2016.
- 3 National Research Council and Institute of Medicine. Strategies for scaling effective family-focused preventive interventions to promote children's cognitive, affective, and behavioral health: Workshop summary. National Academies Press. 2014.
- 4 National Research Council and Institute of Medicine. Preventing Mental, Emotional, and Behavioral Disorders among Young People: Progress and Possibilities. ME O'Connell, TT Boat, KE Warner (Eds.) National Academies Press. 2009.
- 5 Boyce WT. Epigenomics and the Unheralded Convergence of the Biological and Social Sciences. Population Health: Behavioral and Social Science Insights. July 2015. Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services. Available at: <https://www.ahrq.gov/professionals/education/curriculum-tools/population-health/boyce.html>. Accessed March 22, 2018.
- 6 Plough AL. Measuring what matters: Introducing a new action framework. Robert Wood Johnson Foundation, 2015. Available at: www.rwjf.org/en/culture-of-health/2015/11/measuring_what_matter.html. Accessed March 23, 2018.
- 7 Braveman P, Barclay C. Health disparities beginning in childhood: A life-course perspective. Pediatrics. 2009;124(suppl 3):S163–S175.
- 8 Robinson LR, Bitsko RH, Thompson RA, et al. CDC Grand Rounds: Addressing health disparities in early childhood. Morbidity and Mortality Weekly Reports (MMWR). 2017 Jul 28;66(29):769-772.
- 9 Wilkinson R, Marmot M. Social Determinants of Health: The solid facts. (2nd edition). World Health Organization, 2003. Available at: http://www.euro.who.int/_data/assets/pdf_file/0005/98438/e81384.pdf. Accessed March 24, 2018.
- 10 Sege RD, Harper Browne C. Responding to ACEs with HOPE: Health outcomes from positive experiences. Academic Pediatrics. 2017 Sep - Oct;17(7S):S79-S85.
- 11 Fierman AH, Beck AF, Chung EK, et al. Redesigning health care practices to address childhood poverty. Academic Pediatrics. 2016 Apr;16(3 Suppl):S136-S146.
- 12 Steverman SM, Shern DL. Financing mechanisms for reducing adversity and enhancing resilience through implementation of primary prevention. Academic Pediatrics. 2017 Sep - Oct;17(7S):S144-S149.
- 13 Bethell CD, Solloway MR, Guinosso S, et al. Prioritizing possibilities for child and family health: An agenda to address adverse childhood experiences and foster the social and emotional roots of well-being in pediatrics. Academic Pediatrics. 2017 Sep - Oct;17(7S):S36-50.
- 14 Shonkoff JP, Boyce W, McEwen BS. Neuroscience, molecular biology and the childhood roots of health disparities: Building a new framework for health promotion and disease prevention. JAMA. 2009;301(21):2252–2259.
- 15 McEwen BS. Brain on stress: How the social environment gets under the skin. Proceedings of the National Academy of Sciences. 2012;109(Supplement_2):17180–17185.
- 16 Conroy K, Sandel M, Zuckerman B. Poverty grown up: how childhood socioeconomic status impacts adult health. Journal of Developmental and Behavioral Pediatrics. 2010 Feb-Mar;31(2):154-60.
- 17 Marmot M. Social determinants of health inequalities. Lancet. 2005 Mar 19-25;365(9464):1099-104.
- 18 World Health Organization Commission on Social Determinants of Health. Final Report: Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. World Health Organization; 2008. Available at: http://www.who.int/social_determinants/thecommission/finalreport/en/. Accessed March 18, 2018.
- 19 Marmot M, Allen J, Bell R, Bloomer E, Goldblatt P; Consortium for the European Review of Social Determinants of Health and the Health Divide. WHO European review of social determinants of health and the health divide. Lancet. 2012 Sep 15;380(9846):1011-1029.
- 20 Bruner C, Johnson K, Bethell C, et al. Next steps in family-focused screening to address social determinants of health for young children in primary care. Report of the Social Determinants of Health Technical Working Group of the Maternal and Child Health Measurement Research Network. Child and Adolescent Health Measurement Initiative, Johns Hopkins Bloomberg School of Public Health. August 2018.
- 21 Rushton FE, Kraft C. Building brains, forging futures: the pediatrician's role. International Journal of Pediatrics and Adolescent Medicine. 2014;1(1):3-7.
- 22 Bruner C. Connecting Child Health and School Readiness. Colorado Trust. 2009. http://www.coloradotrust.org/sites/default/files/IssueBrief_Bruner_Feb09_Final.pdf. Accessed March 22, 2018.
- 23 Centers for Medicare and Medicaid Services. Medicaid EPSDT Benefits. Available at: <https://www.medicaid.gov/medicaid/benefits/epsdt/index.html>. Accessed July 23, 2018.
- 24 Centers for Medicare and Medicaid Services. What you need to know about EPSDT. Available at: <https://www.medicaid.gov/medic>

[aid/benefits/downloads/what-you-need-to-know-about-epsdt.pdf](#). Accessed July 23, 2018.

- 25 Centers for Medicare and Medicaid Services. Birth to 5: Watch Me Thrive! CMS Efforts to Ensure Children Receive Developmental and Behavioral Screening. 2014. https://www.medicaid.gov/medicaid/quality-of-care/downloads/cms_fact_sheet_dev_screening.pdf. Accessed July 23, 2018.
- 26 Medicaid. Part 5 Manual.
- 27 Centers for Disease Control and Prevention. Screening and Diagnosis for Healthcare Providers. Available at: <https://www.cdc.gov/ncbddd/autism/hcp-screening.html>. Accessed July 23, 2018.
- 28 National Academy of State Health Policy. Developmental Screening Medicaid Policy by State. 2016. Available at: <https://healthychild.nashp.org/wp-content/uploads/2016/04/Final-Developmental-Screening-Policy-Chart-12.20.16.pdf>. Accessed July 23, 2018.
- 29 National Academy of State Health Policy. Developmental and Social-Emotional Screening of Young Children in Minnesota. 2016. Available at: <https://nashp.org/developmental-and-social-emotional-screening-young-children-minnesota/>. Also see: <http://www.health.state.mn.us/divs/cfh/topic/devscreening/>. Accessed July 23, 2018.
- 30 Kerstjens JM, Bos AF, ten Vergert EMJ, et al. Support for the global feasibility of the Ages and Stages Questionnaire as developmental screener. *Early Human Development*. 2009;85(7):443-447.
- 31 Chen CY, Chen CI, Squires J, et al. Adapting a developmental screening measure: Exploring the effects of language and culture on a parent-completed social-emotional screening test. *Infants and Young Children*. 2017;30(2):111-123.
- 32 Briggs RD, Stettler EM, Silver EJ, et al. Social-emotional screening for infants and toddlers in primary care. *Pediatrics*. 2012, Feb;129(2):e377-384.
- 33 Burak EW, Oheh M. Developmental screenings for young children in Medicaid and the Children's Health Insurance Program. Center for Children and Families, Georgetown University Health Policy Institute. March 2018. Available at: <https://ccf.georgetown.edu/wp-content/uploads/2018/03/Dev-Screening-3-15.pdf>. Accessed July 23, 2018.
- 34 Earls MF, Hay SS. Setting the Stage for Success: Implementation of Developmental and Behavioral Screening and Surveillance in Primary Care Practice—The North Carolina Assuring Better Child Health and Development (ABCD) Project. *Pediatrics*. 2006 Jun;118(1):e183-188.
- 35 Gould J. Victory in Washington State: Medicaid developmental screens. Center for Children and Families, Georgetown University Health Policy Institute. Available at: <https://ccf.georgetown.edu/2015/09/09/pediatric-medicaid-developmental-screens-autism-bright-futures>. Accessed July 23, 2018.
- 36 U.S. Department of Education. Individuals with Disabilities Education Act. Early Intervention Services. Statutes/Regulations. Available at: <https://sites.ed.gov/idea/regs/c/a/303.13>. Accessed July 23, 2018.
- 37 Heider F. State Medicaid and early intervention agency partnerships to promote healthy child development. National Academy for State Health Policy. May 2016. Available at: <https://nashp.org/wp-content/uploads/2016/05/Healthy-Child-Brief.pdf>. Accessed July 23, 2018.
- 38 Adams RC, Tapia C, and the AAP Council on Children with Disabilities. Early Intervention, IDEA Part C services, and the medical home: Collaboration for best practice outcomes. *Pediatrics*. 2013 Oct;132(4):e1073-1088.
- 39 Bruner C, Trefz MN. An Arizona opportunity assessment on ensuring young children's developmental success. Child and Family Policy Center. 2003. Available at: <http://www.buildinitiative.org/Portals/0/Uploads/Documents/AZOpportunityAssessmentJuly2013.pdf>. Accessed September 7, 2018.
- 40 Garg A, Dworkin PH. Surveillance and screening for social determinants of health: The medical home and beyond. *JAMA Pediatrics*. 2016 Mar;170(3):1891-90.
- 41 Chung EK, Siegel BS, Garg A, et al. Screening for social determinants of health among children and families living in poverty: A guide for clinicians. *Current Problems in Pediatrics and Adolescent Health Care*. 2016 May;46(5):135-153.
- 42 Bethell CD, Carle A, Hudziak J, et al. Methods to assess adverse childhood experiences of children and families: Toward approaches to promote child well-being in policy and practice. *Academic Pediatrics*. 2017 Sep - Oct;17(7S):S51-69.
- 43 Gottlieb L, Tobey R, Cantor J, Hessler D, Adler NE. Integrating Social And Medical Data To Improve Population Health: Opportunities And Barriers. *Health Affairs*. 2016 Nov 1;35(11):2116-2123.
- 44 Glowa PT, Olson AL, Johnson DJ. Screening for Adverse Childhood Experiences in a Family Medicine Setting: A Feasibility Study. *Journal of the American Board of Family Medicine*. 2016 May-Jun;29(3):303-307.
- 45 Gottlieb LM, Hessler D, Long D, et al. Effects of Social Needs Screening and In-Person Service Navigation on Child Health: A Randomized Clinical Trial. *JAMA Pediatrics*. 2016 Nov 7;170(11):e162521.
- 46 Braveman PA, Egerter SA, Mockenhaupt RE. Broadening the focus: the need to address the social determinants of health. *American Journal of Preventive Medicine*. 2011 Jan;40(1 Suppl 1):S4-18.
- 47 Braveman P, Arkin E, Orleans T, Proctor D, Plough A. What Is Health Equity? And What Difference Does a Definition Make? Princeton, NJ: Robert Wood Johnson Foundation, 2017.

- 48 Braveman P, Heck K, Egerter S, et al. Economic hardship in childhood: a neglected issue in ACE studies?. *Maternal and Child Health Journal*. 2017 Oct 3;1-10.
- 49 Kogan MD, Schuster MA, Yu SM, et al. Routine assessment of family and community health risks: parent views and what they receive. *Pediatrics*. 2004 Jun;113(6 Suppl):1934-1943.
- 50 Morone J. An integrative review of social determinants of health assessment and screening tools used in pediatrics. *Journal of Pediatric Nursing*. 2017 Nov - Dec;37:22-28.
- 51 Child and Adolescent Health Measurement Initiative. Well-Visit Planner. Available at: <http://wellvisitplanner.org/>. Accessed July 23, 2018.
- 52 Bruner et al. 2018. Op cit.
- 53 Pennebaker JW, Susman JR. Disclosure of traumas and psychosomatic processes. *Social Science Medicine*. 1988;26:327-332..
- 54 Becker-Blease KA, Freyd JJ. Research participants telling the truth about their lives: the ethics of asking and not asking about abuse. *American Psychologist*. 2006;61:218-226.
- 55 Bruner C. ACE, Place, Race, and Poverty: Building Hope for Children. *Academic Pediatrics*. 2017 Sep - Oct;17(7S):S123-129.



K. Johnson and C. Bruner. A Sourcebook on Medicaid's Role in Early Childhood: Advancing High Performing Medical Homes and Improving Lifelong Health. Child and Family Policy Center. October 2018.

Part Five

Medicaid Financing for Other Needed Services Promote Healthy Child Development Within and Beyond the Medical Home

Part Five / Key Takeaway Messages

- Many pediatric primary care practices are augmenting their services or increasing linkages with other community providers to better address risks and concerns related to child development, emotional-behavioral factors, or social determinants of health. Evidence-based models to augment primary care — such as HealthySteps and Project DULCE — are being used in practices across the nation.
- Promoting social-emotional health and well-being, beginning in early childhood, is a nationwide priority. Medicaid is financing an array of preventive and therapeutic services for young children, including ones where the services themselves are directed to ameliorating parent risks that affect child health.
- The social-emotional, mental, and behavioral health of young children is a core foundation for the healthy growth and development of young children and is strongly associated with school readiness, achievement, and lifelong health and well-being. EPSDT includes preventive, diagnostic, and treatment services related to mental health and physical health equally. Integrating mental/behavioral health services into primary care is another trend, for children and adults. Early childhood mental health clinicians offer the opportunity to intervene more effectively in the earliest years of life; effective approaches recognize social and emotional concerns at much younger ages than those for traditional mental health diagnoses.
- Medicaid plays a role in financing home visiting and early intervention services. Dedicated federal funding through the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program and the IDEA Part C Early Intervention Program provide a foundation and infrastructure for needed services but themselves have insufficient funding to cover all children in need. Many states are using Medicaid to finance some of the cost for delivery of these services, particularly when related to improving child health outcomes, which falls within the scope of Medicaid and its EPSDT benefit. Even though federal funds cannot be used as a match for Medicaid, state or local funds directed to these programs can.
- Medicaid also provides opportunities for financing other services around parenting training, education, and group interventions that respond to developmental, social, and emotional risks. This generally requires that primary child health practitioners or other medical clinicians provide authorization for such services, that staff are appropriately credentialed to provide the services, and that the goals for and documentation of the services are clearly enumerated and are based on the child's identified health needs.

Augmenting Primary Health Care to Address Bio-Medical and Social Determinants of Health

As discussed throughout this sourcebook, primary care practices are moving toward becoming high-performing medical homes by restructuring their offices and well-child visits and incorporating screening and care coordination as essential elements of their practices. There are such exemplary practices in virtually every state on which to build.

In addition to these features, both states and exemplary practices also are expanding the coverage under Medicaid for additional needed services, sometimes with these services directly incorporated into the practice office and sometimes through practitioner referrals and authorizations for services outside the office. Specific service models have developed a strong evidence base on their effectiveness and have been supported for broad diffusion. Not all services that young children need will be eligible for Medicaid reimbursement (housing subsidies and basic child care, for instance), yet many do fit the Medicaid and

EPSDT benefit, particularly those directed toward improving children's healthy development through training and enhancing parental skills in advancing the child's development. Anticipatory guidance and health education is recommended and covered to promote positive parenting, as well as social-emotional, physical, and cognitive development and any special health care needs. Such services defy neat categorization, but there is a growing body of evidence that suggests they can be integrated into the primary care practice, with financing from Medicaid. Most are evidence-based; many have been shown to have a high return on investment.¹

The other needed services and supports discussed here focus on engaging parents and children to improve the health and development of young children through more positive parenting, home safety and security, and early interventions to address social and bio-medical determinants of health.

Augmenting Primary Health Care Office Responses by Incorporating Additional Services within the Practice Setting

Building such capacity within the pediatric primary care medical home is one highly promising strategy. Typically, this is done by adding a staff person who has developmental knowledge and clinical skills. Evidence-based program models (e.g. HealthySteps and Project DULCE) are being implemented across the country. In addition, other types of staff may be added to provide preventive services and support parents within the practice or in the community. These strategies make particular sense for larger private practices and for federally qualified health centers and other clinics, where patient volume is likely to be sufficient to keep a staff person fully deployed. Smaller practices also may be able to have such onsite staff, however, particularly on a rotating basis across several sites, where the staff are available for specific days or times during the week. Below are examples.

- **Preventive Services Delivered by Non-Physicians.** At their option, with a state plan amendment, states can choose to reimburse preventive services “recommended by a physician or other licensed practitioner...within the scope of their practice under State law” (42 CFR §440.130(c)). Medicaid can provide reimbursement for preventive services staffed by a broad array of health and related staff. Those include community health workers, parent educators, early childhood specialists, and nutrition counselors and lactation consultants.²

Primary care practices are moving toward becoming high-performing medical homes by restructuring their offices and well-child visits and incorporating screening and care coordination as essential elements. There are such exemplary practices in virtually every state on which to build.

- **Project DULCE (Developmental Understanding and Legal Collaborations for Everyone)** is an evidence-based effort that uses a protective factors approach. It incorporates components of the Medical-Legal Partnership model to ensure that families have access to the resources they need. Initially established as a research program at Boston Medical Center, Project DULCE improved parental knowledge of child development, better met family needs for concrete services, and successfully engaged and produced substantial gains in parental resiliency for families determined to be at risk.³ Based at the infant's primary care medical home and supporting families for the first six months, a DULCE family specialist joins the health care team and provides additional support on healthy child

development and parenting support by helping parents connect to both formal and informal community resources. The Center for the Study of Social Policy and city and county partners are testing the adoption and adaptation of DULCE in localities across the United States.

- **HealthySteps for Young Children (HealthySteps)** is an evidence-based model that originated in 1996 with partnerships formed with 24 pediatric and family practice sites across the country. The goal of HealthySteps was to design and test a new approach to primary care for young children that would focus on supporting parents in nurturing their child's development. HealthySteps specialists—nurses, nurse practitioners, child development specialists, or social workers—are integrated into the primary practice to respond to the family's needs for information and support about their child's healthy development. The 2003 national evaluation of more than 4,500 children served by 15 HealthySteps sites showed impressive gains in improving timely well-child visits, childhood immunizations, developmental screening, family engagement in primary care, breastfeeding, safe sleep, positive mother-child activities, the sensitivity of parents to their children's cues for attention, as well as in reducing the use of harsh disciplinary practices.^{4 5 6} HealthySteps participation is associated with better social-emotional status and reduced child behavior problems. Through a national resource center operating at Zero to Three, HealthySteps continues to be replicated across the country and adapted and further evaluated for its impacts.

Medicaid Financing to Support Early Childhood Social-Emotional-Mental Health

Screening for social-emotional-mental health risks, as well as developmental and social determinants of health, should be part of routine well-child visits. In fact, EPSDT requires screening for physical *and* mental conditions.

The social-emotional, mental, and behavioral health of young children is a core foundation for the healthy growth and development of young children and is strongly associated with school readiness, school success, social relationships with peers, and lifelong health and well-being. EPSDT includes preventive, diagnostic, and treatment services related to mental health and physical health equally. According to the Centers for Medicare & Medicaid Services, the EPSDT benefit assures that health problems, including mental health and substance use issues, are diagnosed and treated early and before they become more complex and their treatment more costly.⁷

Medicaid finances various types of services using different mechanisms. As discussed above, screening for social-emotional-mental health risks, as well as development and social determinants of health, should be part of routine well-child visits. Under federal law, EPSDT requires screening for physical and mental conditions.

For early childhood mental health interventions and treatment, most states require a determination of medical necessity prior to approval of Medicaid billing. This may or may not include a diagnosed condition of the child. Criteria related to risk factors are considered sufficient for determining medical necessity in many cases. The professional judgement of a health professional should be considered sufficient grounds on which to base a medical necessity determination, given that nothing in federal law requires a diagnosis. In addition, some programs (e.g. evidence-based parenting support) might be generally approved, avoiding the need for individual medical necessity determinations. Mental and behavioral health care coordination/case management services also are billable services in a majority of states.

Some states have used Medicaid to support early childhood social-emotional-mental health interventions, but this aspect of the EPSDT benefit has not been fully implemented in most states. A 2017 survey of the 50 states by the National Center for Children in Poverty, *Using Medicaid to Help Young Children and Parents Access Mental Health Services*,⁸ documented how states are using a variety of partnerships, mechanisms, training, and funding approaches, to increase access to early childhood mental health services. (The state counts for 2016 in this section are based on this survey.) For example, in 2016, state Medicaid agencies covered early childhood mental health services provided by a mental health clinician when delivered in the home (46 states), in primary care (45), or via case management/care coordination (44), although the extent of financing and eligibility for the services vary substantially.

Some states have used Medicaid to support early childhood social-emotional-mental health interventions, but this aspect of the EPSDT benefit has not been fully implemented in most states.

Two specific approaches for providing such services—early childhood mental health consultation and parent-child (dyadic) therapy—are discussed below.

- Early childhood mental health consultation is a multi-level preventive intervention that connects mental health professionals with people who work with young children and their families to improve the child's social-emotional and behavioral health and development.⁹ Many states have early childhood mental health consultation programs, often delivered through early care and education settings but also sometimes through primary care settings. States and communities use a variety of funding sources, including mental health (e.g. Project LAUNCH), child care, Title V MCH, and Medicaid dollars to fund such efforts. In 2016, 34 states reported that Medicaid paid for an early childhood mental health specialist to provide services to address a young child's mental health needs in early care and education programs. Medicaid generally is used only when the service is provided for individual children. No states yet are reported to cover consultation to improve program staff skills or other training.
- Parent-child (dyadic) therapy for mental health conditions acknowledges that for young children, mental and behavioral concerns can best be addressed by treating both the parent and the child, increasing parenting capacity to be responsive, nurturing, promote positive behavior, and appropriately interact with the child. Several evidence-based models of parent-child therapy have been developed and are in use nationwide. In 2016, a substantial share of states (38) explicitly covered parent-child dyadic therapy. States vary regarding the settings and type of providers and/or therapy models that may be used, with a majority permitting billing by mental health clinics (37) and primary care practices (29). Some states (12) use specific billing codes for these services, while others use different rules. States generally require a determination of medical necessity for these services. Most states do not set limits on the number of visits, which would be consistent with EPSDT requirements for providing services as determined medically necessary for individual children.
- As an example, Florida's Medicaid agency changed the service description for "individual therapy," renaming it "individual and family therapy" to extend coverage to parent — child dyadic therapy, as well as therapy with the parents alone without the child present or therapy with the child alone. If the child is the Medicaid recipient, therapy with the parent must be focused on the relationship with

the child, and the child's benefit must be documented. As a result, the service can be used for many different therapeutic approaches and the establishment of a specific service code for dyadic therapy was unnecessary for this state.¹⁰

One challenge states and practitioners may cite to providing behavioral health services is that young children may not yet have clearly defined or diagnosable mental or behavioral health conditions. Very young children may exhibit abnormal development, poor attachment to caregivers, or other early signs of serious risk that do not fit into the Diagnostic Classification of Mental Disorders (DSM-V). This means

One challenge is that very young children may exhibit abnormal development, poor attachment to caregivers, or other early signs of serious risk that do not fit into the DSM-V.

that age-appropriate diagnostic codes are needed for young children. The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (originally DC:0-3 and now DC:0-5) supports clinicians in diagnosing and treating mental health problems in the earliest years. Crosswalks have been developed to aid providers in converting DC:0-5 into the diagnostic codes used for adults by most health insurance plans to receive compensation for their services. In some states (e.g. Florida and Minnesota), Medicaid uses several mechanisms for increasing access to early childhood mental health services, including adoption of the DC:0-5 for diagnostic purposes.

Integrating mental/behavioral health services within the medical home is another trend for both children and adults. EPSDT and *Bright Futures* guidelines call for mental health screening, but there is a shortage of pediatric mental and behavioral health providers for children, particularly for young children.¹¹ As a result, many children and families who need prevention and intervention services do not receive them. Referral to appropriate behavioral health services can be challenging for families and primary care pediatricians. Integration of behavioral health care within pediatric primary care offers a unique opportunity for early intervention to prevent behavioral health problems from worsening.

The number innovative approaches for behavioral health integration (BHI) in pediatric primary care practice is increasing.¹² Collocation of mental and behavioral health providers in the pediatric medical home is an important opportunity. Studies on pediatric behavioral health integration indicate that the strongest effect is with a team-based approach in which primary care providers, care managers, and mental health specialists coordinate care.¹³ Medicaid financing can make this type of primary care system enhancement possible, particularly for those medical homes serving high concentrations of children enrolled in Medicaid. Clear definitions, coverage rules, billing codes, adequate reimbursement rates, requirements for medical necessity where appropriate, and managed care contract provisions are needed as the practical mechanisms to finance integrated behavioral health. Often, as part of a medical team, a trained staff person who is not a licensed physician but has a mental health specialization can provide these services. Additional support sometimes can be provided through telemedicine or other means to access additional clinical expertise when needed.

Research is clear that the mental health of the parents, and particularly the mother, affects parent-child relationships and the mental health of the child.¹⁴ Further, this is particularly impactful in the earliest years of a child's life, a time when some mothers experience post-partum depression. A CMS informational bulletin emphasizes the negative impact maternal depression can have on young child development and the role EPDST plays in addressing this condition. CMS encourages maternal depression

screening during EPSDT well-child visits and informs states that pediatric primary health care providers may be permitted to bill for maternal depression screening under the child's Medicaid during well-child visits. (See discussion of screening in part four.) CMS states that Medicaid can cover treatment related to maternal depression under the child's Medicaid enrollment if the child is present and if the treatment directly benefits the child. An example of this type of intervention is parent-child dyadic therapy.

*"If a problem is identified as a result of an EPSDT screen, states have an obligation to arrange for medically necessary diagnostic and treatment services to address the child's needs.... Consistent with current policy regarding services provided for the "direct benefit of the child," such diagnostic and treatment services must actively involve the child, be directly related to the needs of the child and such treatment must be delivered to the child and mother together, but can be claimed as a direct service for the child."*¹⁵

Additional treatment of the mother's depression may be needed (including prescriptions for medication and therapies directed specifically for the mother), which can be covered under Medicaid if she qualifies. At the same time, much can be done under the child's Medicaid coverage to identify maternal depression and strengthen the parent-child relationship, which often contributes to the mother's health as well.

Medicaid Financing in Partnership with through Other State and Federal Programs

Medicaid is not the only federal source of financing for children's health and development and early responses to developmental issues and concerns. Other federal programs—particularly those for home visiting and early intervention—are designed to address children's health and development. Many states provide additional funding to these efforts. Even though federal funds cannot be used as the state match for Medicaid, state or community funds directed to these services can. Medicaid can play a substantial role in financing these other needed services.

Medicaid Financing for Home Visiting

Over the last decade, the knowledge base about home visiting has grown and more than 20 evidence-based models that provide voluntary, structured, home visiting services have been approved, based on federal review. Evidence-based home visiting can have a very strong return on investment, with programs such as the Nurse-Family Partnership shown to save \$5.70 per \$1 invested. Home visiting services, typically for at-risk families, emphasize prevention, often beginning during pregnancy, and have demonstrated impact on a range of maternal and child health outcomes, as well as improvements in parenting skills, economic self-sufficiency, safety, and well-being. Several models give greater emphasis to improving maternal, infant, and young child health, beginning during pregnancy, and show more impact on health outcomes.¹⁶ The AAP and others in child health have called for linkage and integration of the pediatric medical home and home visiting programs.^{17 18}

Even though federal funds cannot be used as the state match for Medicaid, state or community funds directed to these services can. Medicaid can play a substantial role in financing these other needed services.

The federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program provides funding that is used in every state to finance evidence-based home visiting, with \$400 million provided annually. However, current funding is sufficient to reach only a small share of families who might benefit from these services. Medicaid funding cannot be combined with federal funding from the MIECHV program, but Medicaid can be one among several sources of funds states use for home visiting services. Many states use multiple state and local funding streams (as well as federal funding streams, including MIECHV but also TANF, child welfare, and others) to support multiple models of home visiting and address a variety of family risks and needs. Often, states have specific state appropriations for home visiting, many of which predated MIECHV as a funding source. States may find it to their advantage to expand Medicaid to cover home visiting services and therefore draw down additional federal as well as state dollars for those services.

States have been using Medicaid to finance home visiting for over 20 years and continue to evolve in the approaches they use to provide coverage for vulnerable mothers and children. In 2016, Joint Informational Bulletin of the Centers for Medicare and Medicaid Services (CMS) and Health Resources and Services Administration (HRSA) affirmed the flexibility and opportunity states have to do so.

“Medicaid coverage authorities offer states the flexibility to provide services in the home.... However, home visiting programs may include some component services, which do not meet Medicaid requirements, and may require support through other funding options....state agencies should work together to develop an appropriate package of services... may consist of Medicaid-coverable services in tandem with additional services available through other federal, state or privately funded programs.”¹⁹

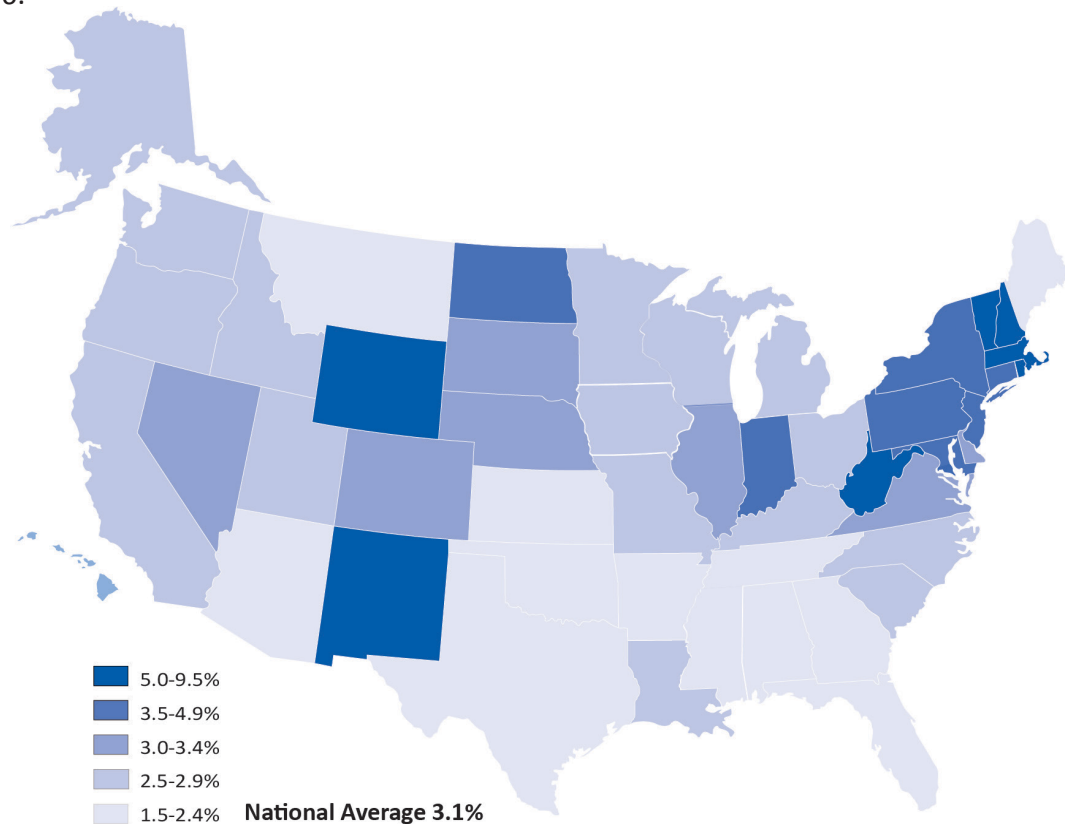
Currently more than a dozen states are using Medicaid financing for home visiting through a variety of mechanisms. In most states, home visiting services are added through a Medicaid State Plan Amendment (SPA). Other states have made home visiting part of larger Medicaid Section 1115 or 1915(b) waivers (e.g. Maryland, South Carolina). Still others use current authority and existing benefits. Different states use fee-for-service, capitated, and managed care approaches.²⁰ Typically, states pay for home visits on a

States have been using Medicaid to finance home visiting for more than 20 years. Currently more than a dozen are using Medicaid financing for home visiting through a variety of mechanisms and benefit categories.

per-visit unit, fee-for-service basis, but it also may be part of per member, per month capitated fees under managed care or provided as a bundled service covering the time period when the visits occur. As states develop Medicaid financing for home visiting, most provide a reimbursement rate that covers the full cost of providing that service, recognizing that all the aspects of providing home visiting (including direct time with the parent and child around child-specific developmental issues and the home visitor’s other time related to that work) are covered in the reimbursement. The examples below show the different ways that states have drawn down funding for home visiting.

- Oklahoma has a long history in home visiting policy and was one of the first states to use Medicaid to pay for home visiting. Oklahoma’s Nurse-Family Partnership program is known as Children First. By 1998, Oklahoma had an agreement between the Department of Health and the Medicaid agency (Oklahoma Health Care Authority) to finance Children First in all 77 counties. Services may be billed to Medicaid with codes for targeted case management (HCPC23 T1017) or nurse assessment (HCPC T1001). State officials report that Medicaid currently represents approximately 15-20 percent of

Figure 15. Percentage of Infants and Toddlers Birth to 3 Receiving Part C Early Intervention Services by State, 2016.



Source: U.S. Department of Education, EDFacts Metadata and Process System (EMAPS): "IDEA Part C Child Count and Settings Survey," 2016. Data extracted as of July 12, 2017. U.S. Bureau of the Census. "2016 State Population Estimates by Age, Sex, Race, and Hispanic Origin". Data accessed July 2017 from <http://www.census.gov/popest>

funding for Children First each year. In FY 2016, Children First served about 2,500 families in Oklahoma, with 90 percent receiving coverage through Medicaid. The Medicaid approach is supported by a strong and enduring partnership between the state's Medicaid agency and Department of Health. By 2016, more than 100 registered nurses who meet home visiting training requirements were certified by the Department of Health for this program.

- Michigan has been using Medicaid to finance home visiting for more than two decades. Multiple models are being used with state and MIECHV funding, but the centerpiece of their statewide effort is the Medicaid Maternal and Infant Health Program (MIHP). MIHP is administered by the state Medicaid agency. Michigan used maternal and infant case management programs from which to build MIHP as a strong, population-based home visiting program that is available to all pregnant women in Medicaid. MIHP has been shown through evaluation studies to improve utilization of pre-natal care and well-baby visits; and to reduce the risk of adverse birth outcomes, particularly among black women.²¹ In 2017, after years of operation as a fee-for-service Medicaid program, MIHP was integrated into Medicaid managed care arrangements.
- Minnesota has been using Medicaid to finance home visiting for more than a decade. The state currently authorizes Medicaid managed care contracts with local health departments providing home visiting services. Multiple models of home visiting are being used (e.g. Nurse Family Partnership,

Healthy Families America, and Family Spirit). All of the managed care organizations contracting with the state have subcontracts with local agencies to provide home visiting services. However, local agencies have been individually contracting with managed care organizations and as a result home visiting agency reimbursement rates, responsibilities, and results are inconsistent across the state.

- The Kentucky’s Health Access Nurturing Development Services (HANDS) program is administered by the Kentucky Department of Public Health. HANDS began as a pilot program in 1999 and was expanded to every county in the state by 2003. This expansion was fueled by Medicaid financing. In 2002, the state got a Targeted Case Management SPA approved to cover some HANDS home visiting; the state used State Tobacco Funds as the state match for federal Medicaid dollars. Kentucky covers HANDS services through a fee-for-service system even though the majority of Medicaid beneficiaries are enrolled in managed care.

The structure of these efforts depends primarily on the benefit category used.²² Under the Medicaid State Plan Authority there is no official benefit called “home visiting”; however, home visiting services can be covered under some benefit categories, typically targeted case management, expanded services to pregnant women, and EPSDT. Most states have used the Targeted Case Management benefit option to finance home visiting, which offers flexibility and fiscal controls. Using the Targeted Case Management benefit option requires that a state submit and CMS approve a Medicaid State Plan Amendment, in which the

Under the Medicaid State Plan Authority there is no official benefit called “home visiting,” but home visiting services can be covered under some benefit categories.

state may define risk criteria for family eligibility, set provider qualifications (e.g. select models), define the structure of the service, set payment rates, and even select specific geographic areas if it so chooses. The overlap between EPSDT prevention benefits and home visiting services offers an opportunity for EPSDT to be used as a permissible benefit pathway for the coverage of services.²³ Typically, states use the EPSDT child health benefit combined with optional enhanced maternity benefits.

In any case, states are not using medical necessity determinations or prior authorization limits related to Medicaid financing of home visiting. Instead, it is typically added as a covered service under an appropriate benefit category with risk criteria for eligibility generally aligned with the models used.

States using Medicaid to finance some home visiting services must continue funding staff training, evaluation, central intake, and similar home visiting system elements with MIECHV or other funds. Such activities would not typically qualify for Medicaid payment, even in the health system.

IDEA Part C Early Intervention Program for Infants and Toddlers

Children with confirmed disabilities—physical, developmental, or mental—generally qualify for programs that support their families’ efforts to care for them. In particular, Medicaid, the Supplemental Security Income and associated Medicaid eligibility, the Individuals with Disabilities Education Act (IDEA) Part C Early Intervention for Infants and Toddlers and Part B Special Education for children 3 to 21, and the Title V Children with Special Health Care Needs (CSHCN) programs operate in every state. Medical homes for children should play an important role in helping families identify risks, needs, and follow up interventions, including services provided in these federal programs.²⁴

Part C of the IDEA provides grants to states for Early Intervention Programs for Infants and Toddlers with Disabilities (20 U.S.C §1435(a)(1), P.L. 108-446 §635(a)(1)) and requires that states provide early intervention services to children identified as qualifying for them.^{25 26} States must use a comprehensive outreach approach (known as “child find”) and referral system, as well as access to timely and comprehensive multidisciplinary evaluations to identify needs. States must assure that every eligible child and family will have early intervention services eligible to them and use Individualized Family Service Plans (IFSP) to specify and guide services, as well as care coordination services. Although the federal grant is a limited \$347 million, it generally provides for the infrastructure for states to operate their Part C program. Most states provide substantial additional state, local, Medicaid, and private insurance funding to provide the services identified as needed under Part C.

Each state Part C program is required to establish eligibility criteria for serving, at a minimum, children who have: 1) a diagnosed physical or mental condition with a high probability of resulting in developmental delay; or 2) developmental delays in one or more of five domains (i.e. physical, cognitive, communication, social/emotional, and adaptive development). At their option, states are permitted to make eligible children who would be at risk of experiencing a substantial developmental delay if early intervention services were not provided to the individual. Also the state’s option, at-risk infants and toddlers “may include those who are at risk of experiencing develop-

A majority of state Part C programs use Medicaid to fund some of the health-related services for infants and toddlers.

mental delays because of biological or environmental factors that can be identified (including low birth weight, respiratory distress as a newborn, lack of oxygen, brain hemorrhage, infection, nutritional deprivation, a history of abuse or neglect, and being directly affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure).²⁷ Since 2005, states have had the flexibility to make Part C early intervention services available to children until they are eligible to enter kindergarten or elementary school, thereby offering families additional support and children enhanced services that would not typically be included in IDEA Special Education services for ages 3-5.

Federal law requires that states use a “rigorous definition of the term ‘developmental delay,’”²⁸ yet states set their own eligibility criteria for Part C. These vary widely and can require an identified delay of 25 percent or more to trigger eligibility, which often is difficult to meet, particularly for very young children.²⁹ As a result, eligibility and enrollment varies widely among the states. National survey data indicate that the proportion of infants and toddlers who have conditions making them likely to be eligible for Part C services ranges from 2 percent to more than 50 percent — with the most cited study estimating that 12-28 percent of all children should qualify.^{30 31} As shown in the map in Figure 12, the proportion of infants and toddlers enrolled in Part C, however, ranges from across states from 1 percent to 9 percent.

Medicaid plays a particularly important role in financing services that help children with developmental disabilities or chronic medical conditions, including those in the IDEA Part C Early Intervention program. A majority of state Part C programs use Medicaid to fund some of the health-related services for infants and toddlers.³² Intervention services on behalf of Part C-enrolled children most likely to be funded by Medicaid are physical, occupational, and speech/language therapies. Psychological, nutritional, diagnostic medical, vision, developmental therapy, and assistive technology services also can be covered. Part C services generally involve extensive communication with the parents of the children, and support to them in providing home-based environments to improve their children’s development.

In many states, Medicaid has developed partnerships with Part C to maximize the funding for Part C services and improve outcomes. Medicaid financing is used by virtually all states to finance a portion of Part C Early Intervention services. Making referral, service delivery, and payment practices efficient and effective helps reduce cost and improve outcomes. Medicaid financing for Part C has been restructured in some states as more young children are enrolled in managed care arrangements.³³

At the same time, an estimated 10 to 25 percent of young children with developmental risks or delays that have not yet resulted in disability do not qualify for Part C Early Intervention under the state definitions for eligibility. In many states, more than one-third of children with identified developmental concerns referred to Part C do not qualify. Many of these risks associated with later onset developmental delays and disabilities are related to social determinants described earlier in this sourcebook.³⁴ State Medicaid agencies can structure and support a network of providers who have the capacity to serve children with or at risk of developmental delays who do not qualify for Part C. Doing so adheres to the Medicaid statute and its EPSDT benefit. Medicaid agencies, in partnership with Title V CSHCN programs in particular, have worked to develop such provider capacity. For example, Rhode Island developed the Comprehensive Evaluation, Diagnosis, Assessment, Referral, and Reevaluation (CEDARR) program, which has been modernized to provide Medicaid health homes.³⁵

Family First

On February 9, 2018, the Family First Prevention Services Act was signed into law as part of the Bipartisan Budget Act of 2018 (P.L. 115-123).³⁶ The Family First Act includes major reforms intended to: avoid foster care placements by keeping children safely with their families; emphasize the importance of children growing up in families; and ensure children are placed in the least restrictive, most family-like setting appropriate to their needs when foster care is needed.³⁷ Notably, children in foster care qualify for Medicaid, as do many other children at risk for entering foster care.

The potential exists for states' child welfare and Medicaid agencies to work in partnership to maximize available funds, increase service capacity, and provide treatment services for pregnant women, infants, children, and youth.

Setting a new direction, the Family First Act provides new optional Title IV-E funding for time-limited (one year) prevention services for mental health/substance abuse and in-home parent skill-based programs for candidates for foster care without regard to whether the child would be eligible for Title IV-E foster care, adoption, or guardianship, pregnant/parenting foster youth, and the parents/kin caregivers of those children and youth (sections 471(e), 474(a)(6) and 475(13) of the Act). Eligible groups include: 1) children who are "candidates" for foster care, meaning they are identified in a prevention plan as being at imminent risk of entering care but can safely remain at home or in a kinship placement if provided services that prevent

entry into foster care or whose adoption or guardianship arrangement is at risk of disruption or dissolution that would result in entry into foster care; 2) children in foster care who are pregnant or parenting; and 3) parents or kin caregivers of candidates for foster care where services are needed to prevent the child's entry into care or directly relate to the child's safety, permanence or well-being. Eligible children, youth, parents and kin caregivers are eligible for prevention services and programs regardless of whether they meet the AFDC income-eligibility requirements required for Title IV-E reimbursement.

The preventive services program emphasizes: 1) mental health and substance abuse prevention and

treatment services provided by a qualified clinician, and 2) in-home parent skill-based programs, which include parenting skills training, parent education and individual and family counseling. State agencies and child advocates are starting to envision programs that might use the 12-month funds to: increase the capacity to provide: parent-child dyad mental health therapy, trauma-informed services, maternal depression treatment, home visiting models designed for families whose young children are in or at risk of entering the child welfare system, interventions to reduce opioid exposure during pregnancy, and other services.

The potential exists for states' child welfare and Medicaid agencies to work in partnership to maximize available funds, increase service capacity, and provide treatment services for pregnant women, infants, children, and youth. For example, if Family First time-limited funds were used to spread use of evidence-based child welfare interventions, Medicaid might be used in tandem to fund mental health, developmental, or substance use treatment services.

Medicaid Financing to Support Effective Parenting

Parents' knowledge of how to meet their children's basic physical and emotional needs has effects on parent-child relationships and, in turn, child health and development.³⁸ The appropriateness and skill of parents in delivering discipline is equally important. Anticipatory guidance from the pediatric primary care practitioner is intended to help parents prepare for and address issues they may encounter as their child grows. *Bright*

Futures guidelines recommend anticipatory guidance across a broad variety of topics that are focused on parental roles in their child's health and development. As discussed throughout this sourcebook, some families need coaching, support, and guidance that goes beyond what can effectively be delivered in well-child visits. Evidence-based home visiting programs offer coaching and support for positive parenting and have been shown to have significant impact. Other evidence-based programs are designed to provide more intensive support to parents (e.g. Triple P Positive Parenting Program,^{39 40} The Incredible Years^{41 42}) and can be financed through Medicaid. These may be provided in clinical sites such as pediatric practice offices, community health centers, or hospitals or may be provided in other human service office sites. Two state examples point to opportunities.

Some families need coaching, support, and guidance that goes beyond what can effectively be delivered in well-child visits.

- In Michigan, Community Mental Health Services Programs can choose the evidence-based parenting models they offer. Models used include: Nurturing Parenting Program and The Incredible Years. A diagnosis is required for billing Medicaid but the diagnosis can be for the parent or child.
- In Oregon, services within select parenting programs are covered when a child has a diagnosis and a parent training program is recommended as the best treatment for that diagnosis (e.g. The Incredible Years, Parent Management Training programs). Parents can participate in a parenting program if their child is "at risk" of experiencing a mental health disorder as a result of family circumstances that increase the child's chance of developing a significant mental health condition. Oregon's health care providers may bill Medicaid for children's mental health services under a new code indicating the presence of family and environmental factors that place the child "at risk" of a mental health disorder (using the ICD-10 code, Z63.8).

States also have the option to use Medicaid to finance other parent support services available in their communities. Typically, referral from a primary care practitioner is required and the parent support programs must have structures (appropriately credentialed staff, protocols for providing service, and documentation systems) that enable them to be Medicaid providers.

States have the option to use Medicaid to finance parent support services. Typically, referral from a primary care practitioner is required and the parent support programs must have the structures that enable them to be Medicaid providers.

Some of these parenting programs and services involve direct training and modeling (dyadic) activities with individual parents and those parents and their children, and there also are opportunities for group activities, and for peer interactions. This includes group medical visits (e.g. drop-in group medical appointments-DIGMAs) and patient support groups. These have been employed with respect to well-child visits and show promise of extending the range of topics and issues that can be covered. Patient support groups — often around specific conditions (such as children with autism or ADHD) can provide additional contacts and ties for children and their families that strengthen the overall environment for children.

Home-visiting programs like Child First build in such patient support groups, recognizing the value of peer-networking that provides additional opportunities for self-help, reciprocity, and the maintenance of social ties that also are associated with healthy child growth and development. Medicaid recently provided guidance to states on how patient support groups can be covered — and these can have specific applicability to young children and their families. Even though most of the services provided under Medicaid are done on an individual patient basis, Medicaid also provides coverage for group-based services, and these hold the potential for further responding to social determinants of health that impact children's development.

References

- 1 Karoly LA, Kilburn MR, Cannon JS. Early childhood interventions: Proven results, future promise. RAND Corporation. 2005. Available at: <https://www.rand.org/pubs/monographs/MG341.html>. Accessed June 3, 2018.
- 2 Burton A, Chang DI, Gratale D. Medicaid funding of community-based prevention: Myths, state successes overcoming barriers and the promise of integrated payment models. Nemours. 2013.
- 3 Sege R, Preer G, Morton, SJ et al. Medical-legal strategies to improve infant health care: A randomized trial. *Pediatrics*.2015;136(1):2014-2955.
- 4 Piotrowski CC, Talavera GA, Mayer JA. Healthy Steps: A systematic review of a preventive practice-based model of pediatric care. *Journal of Developmental and Behavioral Pediatrics*. 2009;30(1):91–103.
- 5 Niederman LG, Schwartz A, Connell KJ, Silverman K. Healthy Steps for Young Children Program in pediatric residency training: Impact on primary care outcomes. *Pediatrics*. 2007;120(3):e596–603.
- 6 Minkovitz CS, Strobino D, Mistry KB, et al. Healthy Steps for Young Children: Sustained results at 5.5 years. *Pediatrics*. 2007;120(3):e658–e668.
- 7 Centers for Medicare and Medicaid Services. Prevention and early identification of mental and substance use conditions. Available at: <http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-27-2013.pdf>. Accessed June 23, 2018.
- 8 Smith, S., Granja, M., Ekono, M., Robbins, T., Nagarur, M. Using Medicaid to help young children and parents access mental health services: Results of a 50-state survey. National Center for Children in Poverty, Mailman School of Public Health, Columbia University. 2016.
- 9 Center of Excellence for Infant and Early Childhood Mental Health Consultation. Overview of the IECMHC approach within the early

childhood system. Available at: <https://www.samhsa.gov/sites/default/files/overview-iecmhc-approach-within-early-childhood-system.pdf>. Accessed July 25, 2018.

- 10 Oser C. Nurturing change: State strategies for improving infant and early childhood mental health. Zero to Three. 2013. Available at: <https://www.zerotothree.org/resources/122-nurturing-change-state-strategies-for-improving-infant-and-early-childhood-mental-health>. Accessed July 25, 2018.
- 11 Committee on Psychosocial Aspects of Child and Family Health and Task Force on Mental Health, American Academy of Pediatrics. Policy statement: The future of pediatrics: mental health competencies for pediatric primary care. *Pediatrics*. 2009;124(1):410-421.
- 12 Tyler ET, Hulkower RL, Kaminski JW. Behavioral health integration in pediatric primary care: Considerations and opportunities for policymakers, planners, and providers. Milbank Memorial Fund. March 2017. Available at: https://www.milbank.org/wp-content/uploads/2017/03/MMF_BHI_REPORT_FINAL.pdf. Accessed July 25, 2018.
- 13 Talmi A, Muthé E, Margolis K, et al. The scope of behavioral health integration in a pediatric primary care setting. *Journal of Pediatric Psychology*. 2016;41(10):1120-1132.
- 14 Institute of Medicine. Strategies for scaling tested and effective family-focused preventive interventions to promote children's cognitive, affective, and behavioral health: Workshop in brief. National Academies Press. 2015.
- 15 Centers for Medicare and Medicaid Services. Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children. CMCS Informational Bulletin. May 2016. Available at: <https://www.medicare.gov/federal-policy-guidance/downloads/cib051116.pdf>. Accessed July 25, 2018.
- 16 U.S. Department of Health and Human Services. Home visiting evidence of effectiveness. Available at: <https://homvee.acf.hhs.gov/>. Accessed July 25, 2018.
- 17 Tschudy M, Toomey, Cheng TL. Merging systems: Integrating home visitation and the family-centered medical home. *Pediatrics*. 2013;132:S74-81.
- 18 Duffee JH, Mendelsohn AL, Kuo AA, Fegano LA, Earls MF, Council on Community Pediatrics, Council on Early Childhood, Committee on Child Abuse and Neglect. Early childhood home visiting: policy Statement of the American Academy of Pediatrics. *Pediatrics*. 2017;140(3):e2017-2150.
- 19 Centers for Medicare and Medicaid Services and Health Resources and Services Administration. Coverage of maternal, infant, and early childhood home visiting services. Joint Information Bulletin, March 2016. Available at: <https://www.medicare.gov/federal-policy-guidance/downloads/cib-03-02-16.pdf>. Accessed July 25, 2018.
- 20 Normile B, King A, VanLandeghem K. Medicaid financing of home visiting services for women, children and their families. National Academy for State Health Policy. 2017.
- 21 Meghea CI, You Z, Raffo J, Leach RE, Roman LA. Statewide Medicaid enhanced prenatal care programs and infant mortality. *Pediatrics*. 2015 Aug;136(2):334-342.
- 22 Johnson K. Using Medicaid to finance home visiting services: A checklist for state decision makers. Johnson Group Consulting, Inc. 2016.
- 23 Rosenbaum S. Technical Memorandum regarding CMS/HRSA Informational Bulletin on coverage of maternal, infant, and early childhood home visiting services. George Washington University. March 16, 2016.
- 24 Adams RC, Tapia C, and AAP Council on Children with Disabilities. Early Intervention, IDEA Part C services, and the medical home: Collaboration for best practice and best outcomes. *Pediatrics*. 2013;132:e1073-1088.
- 25 Congressional Research Service. In Individuals with Disabilities Education Act (IDEA), Part C: Early Intervention for Infants and Toddlers with Disabilities. U.S. Library of Congress. June, 2017.
- 26 Part C IDEA Infants and Toddlers with Disabilities Statute and Regulations. Available at: <http://ectacenter.org/partc/303regs.asp>. Accessed July 25, 2018
- 27 Council for Exceptional Children. Individuals with Disabilities Education Act Part C: Early intervention program for infants and toddlers with disabilities. Final regulations side-by-side comparison. October 2011. Available at: <https://www.cec.sped.org/~media/Files/Policy/Early%20Learning/Finished%20Part%20C%20Regs.pdf>. Accessed July 25, 2018.
- 28 Early Childhood Technical Assistance Center. States' Part C Rules, Regulations and Policies. Available at: <http://www.ectacenter.org/partc/statepolicies.asp>. Accessed July 25, 2018.
- 29 Bruner C, Trefz MN. An Arizona opportunity assessment on ensuring young children's developmental success. Child and Family Policy Center. 2003. Available at <http://www.buildinitiative.org/Portals/0/Uploads/Documents/AZOpportunityAssessmentJuly2013.pdf>. Accessed September 7, 2018.
- 30 Rosenberg SA, Robinson CC, Shaw EF, Ellison MC. Part C Early Intervention for Infants and Toddlers: Percentage eligible versus served. *Pediatrics*. 2013;131:38-46.
- 31 Rosenberg SA, Zhang D, Robinson CC. Prevalence of developmental delays and participation in early intervention services for young children. *Pediatrics*. 2008;121(6):e1503-1509.
- 32 IDEA Infant and Toddler Coordinators Association. Options and considerations when accessing Medicaid Early Periodic Screening,

Diagnosis and Treatment (EPDST) for Part C Services. Available at: http://www.ideainfanttoddler.org/pdf/EPDST_Paper.pdf. Accessed July 25, 2018.

- 33 Fox HB, McManus MA, Almeida RA. Managed care's impact on Medicaid financing for early intervention services. *Health Care Financing Review*. 1998;20(1):59–72.
- 34 Nelson BB, Dudovitz RN, Coker TR, et al. Predictors of poor school readiness in children without developmental delay at age 2. *Pediatrics*. 2016;138(2):e2015-4477.
- 35 Community Catalyst. Health Homes: Rhode Island's development of a pediatric health home model. 2012. Available at: <http://neach.communitycatalyst.org/issue/affordable/asset/RI-Health-Homes.pdf>. Accessed July 26, 2018.
- 36 U.S. Administration for Children and Families. Information Memorandum. Family First Prevention Services Act. (ACYF-CH-IM-18-02.) April 12, 2018. <https://www.acf.hhs.gov/sites/default/files/cb/im1802.pdf>. Accessed July 10, 2018.
- 37 Children's Defense Fund. The Family First Prevention Act. 2018. Available at: <https://www.childrensdefense.org/wp-content/uploads/2018/08/family-first-detailed-summary.pdf>. Accessed August 30, 2018.
- 38 National Academies of Sciences, Engineering, and Medicine. Parenting matters: Supporting parents of children ages 0-8. VL Gadsden, M Ford, H Breiner (Eds). National Academies Press. 2016.
- 39 Thomas R, Zimmer-Gembeck MJ. Behavioral outcomes of parent-child interaction therapy and Triple P—Positive Parenting Program: A review and meta-analysis. *Journal of Abnormal Child Psychology*. 2007 Jun 1;35(3):475-495.
- 40 Sanders MR, Kirby JN, Tellegen CL, Day JJ. The Triple P-Positive Parenting Program: A systematic review and meta-analysis of a multi-level system of parenting support. *Clinical Psychology Review*. 2014 Jun;34(4):337-357.
- 41 Webster-Stratton C. A randomized trial of two parent-training programs for families with conduct-disordered children. *Journal of Consulting and Clinical Psychology*. 1984;52(4): 666-678.
- 42 Webster-Stratton C. Enhancing the effectiveness of self-administered videotape parent training for families with conduct-problem children. *Journal of Abnormal Child Psychology*. 2000;18(5):479-492.



K. Johnson and C. Bruner. A Sourcebook on Medicaid's Role in Early Childhood: Advancing High Performing Medical Homes and Improving Lifelong Health. Child and Family Policy Center. October 2018.

Part Six

Optimizing Payment Approaches to Support and Sustain High Performing Medical Homes

Part Six / Key Takeaway Messages

- Medicaid can and should play a lead role in advancing high performing medical homes for young children. Payment approaches should cover the costs of needed services, incentivize high performance, ensure that services meet standards of care, and result in improving outcomes for low-income young children served.
- This can be done through both direct, fee-for-service payment systems or under managed care arrangements. Regarding fee-for-service environments, a key step is to establish Medicaid reimbursement levels sufficient to finance and incentivize high performing pediatric medical homes. Appropriate billing codes, service definitions, provider qualifications, and measurement are needed.
- For Medicaid provided through managed care arrangements, states must incorporate into contracts with managed care organizations (MCOs) and accountable care organizations (ACOs) specific expectations and requirements for finance and delivery of high performing medical homes for young children and other services in line with the EPSDT benefit. This requires distinguishing services for young children from services for other populations in the Medicaid contract and establishing payment structures and distinct performance incentives. In particular, contracts and payment mechanisms should emphasize the preventive and developmental services needed to improve the health and well-being of young children in Medicaid in both the short and long term.
- Three specific payment approaches common to managed care contracts — per member per month payments, pay-for-performance, and use of “shared savings” — also can be used to advance the development of high performing pediatric homes, but they are not a substitute for the other actions described above.
- Medicaid administrative claiming can be used to cover administrative activities needed to maximize the effectiveness and efficiency of high performing medical homes. State Title V Maternal and Child Health programs often are in the position to provide or contract for administrative services related to Medicaid (e.g., related provider training, system coordination, measurement) and bill for administrative costs.

Financing Approaches to Support Practice Transformation and High Performing Medical Homes for Young Children

Children, and particularly young children, are not “little adults.” They need services and supports that address their unique health and developmental status. The focus should be on improving health trajectories to health and well-being during childhood and over a lifetime. This section discusses Medicaid financing specifically as it relates to high performing medical homes, with emphasis on primary, preventive, and developmental services for young children and their families.

As the insurer of a majority of young children, Medicaid can and should play a lead role in diffusing the implementation of high performing medical homes for young children and, eventually, making it the expected standard of care.¹ To move from exemplary practices consistent with the description of a high performing medical home to the pediatric standard of care defined in *Bright Futures* will require states to develop Medicaid reimbursement systems, supported by clear and strong service definitions, billing codes, service provider guidelines, contracts, and measurement approaches.

Certainly there will be savings and returns on investment from the improved child health trajectories and therefore fewer medical conditions requiring treatment services, yet most of these will be realized well into the future and not in the timelines of current Medicaid expenditures (i.e., within an annual or biennial Medicaid budget or a Medicaid managed care contractual cycle). Savings can be expected, however, in reduced costs for health care of those with developmental and other disabilities, special education programs, and chronic health conditions from childhood to adulthood. Thus, while short-term savings may not accrue to contracting providers or plans, the public sector will have an overall return on investment in the long run.

In general, achieving improved outcomes will require increased investments in and or expenditures for effective primary, preventive, and developmental services for young children through high performing medical homes. State Medicaid financing systems must be structured to reimburse and incentivize the different services for young children described in parts two through five.

Whether operating under a fee-for-service system or a managed care system, the state has the same responsibility and legal requirements under Medicaid and EPSDT to provide necessary services to children. This may be operationalized through state rules regarding payments or contracts and enforcement provisions in those contracts. Moving to managed care does not eliminate the need for the state to promote and ensure that young children receive the services to which they are entitled, and particularly those governed under EPSDT.

To move to the pediatric standard of care defined in *Bright Futures* will require states to develop Medicaid reimbursement systems, supported by clear and strong service definitions, billing codes, service provider guidelines, contracts, and measurement approaches.

Whether operating through a state fee-for-service system or a managed care system, every state is in the position to define and establish standards for services and set payment levels that support and sustain high performing medical homes for young children. In short, there are opportunities for promoting and advancing high performing medical homes for young children, but, to do so, state Medicaid agencies need to be explicit in expectations, oversight, and financing incentives to providers and/or MCOs/ACOs.

Financing Through Managed Care and Accountable Care Organizations

The term “managed care” is used to describe several different arrangements for delivering and financing health care services. Over 70 percent of all Medicaid enrollees — and more than 80 percent of young children in Medicaid — receive care in managed care arrangements, including comprehensive risk-based plans through MCOs, primary care case management (PCCM) programs, and limited-benefit plans. To date, 39 states have incorporated MCOs into their Medicaid programs.²

Since most children in Medicaid are covered under managed care, it is important to understand the operational dynamics of managed care. MCOs are designed with the goal of simultaneously improving health care quality, improving population health, and containing or reducing per-capita health care costs (the “triple aim”).³ They are not, however, charitable institutions and the bottom line for them is achieving a reasonable return-on-investment (profit) through their Medicaid contracts.

Whether operating through a state fee-for-service system or a managed care system, every state is in the position to define and establish standards for services and set payment levels that support and sustain high performing medical homes for young children.

In general, state Medicaid offices contract with MCOs in order to contain or reduce overall Medicaid costs, while still maintaining quality of care and population health. They must follow federal rules in doing so.⁴ States typically structure incentives for MCOs for achieving those cost savings or offsets. The rationale is that, by providing MCOs greater flexibility in what they cover and provide, particularly in “managing” care to “maintain health,” there is reduced need for and use of more expensive care and treatment. There are several strategies MCOs can use to achieve these ends.

1. One strategy is through managing care to better maintain health and therefore prevent the occurrence or re-occurrence of illness, injury, or acute episodes requiring medical intervention. This is often done through additional care coordination or case management, particularly for enrollees currently experiencing high medical expenses and having chronic conditions that can give rise to acute episodes entailing high-cost medical services (particularly hospitalizations and emergency room use). The major costs within Medicaid go to providing services to persons with disabilities and others with complex medical and chronic conditions requiring expensive care. Managing their care to minimize relapses and control their conditions to prevent avoidable hospitalizations or emergency room treatments can reduce overall costs, even if there are attendant costs for case management.
2. Another strategy includes negotiating lower payment rates for provided services and reducing, through prior authorizations or limits on the units of service provided or other means, provision of unnecessary, duplicative, or ineffective services. These also are the primary ways direct, fee-for-service Medicaid systems seek to contain costs.
3. A third approach is offering incentives (or sanctions) to direct care providers to find ways to better address their patients’ health needs. This can include per member per month (PMPM) payments for care coordination or case management services designed directly to either better maintain health or reduce overutilization of services or incentives (pay for performance bonuses or increased payments or even shared savings) for achieving certain goals with respect to the patients under care.
4. The 2016 federal Medicaid managed care regulation also permits states to use arrangements with MCOs and managed care contracts to substitute certain services for those normally covered under state plans. (42 CFR §438.3(e)(2)) They might, for example, to finance home visits for new mothers rather than in-office mother and infant care. This flexibility to provide other types of care in lieu of normally covered services has promise for addressing social determinants of health, increasing emphasis on developmental risk, and providing more intensive care coordination. Although no MCOs has yet developed “in lieu of” agreements with their states, some have expressed interest in doing so.⁵

Select Approaches to Promote High Performing Medical Homes for Young Children

Three approaches often used by MCOs/ACOs have utility in financing high performing medical homes. First are payments to practices on a “per member per month” (PMPM) basis or prospective capitation payments. A second payment approach is “pay-for-performance,” with payments tied to performance on

specified process and outcome measures. A third approach sets aside some “shared savings” achieved from containing or reducing health costs to be used, generally by the MCO/ACO with oversight by the state contractor, in innovation and continuous improvement activities. These are often through demonstration projects, to seek further health improvements (again, usually for developing alternative care approaches that achieve the “triple aim,” and particularly the third aim of lowering per-capita health care costs). Currently, these approaches are used primarily with complex, chronic, and high-cost patients—generally adults. They could, however, equally be used to promote the health and development of young children. They are discussed below.

PMPM or capitation payments to practices can be used to finance primary and preventive care for children. They also can be used to finance the more intensive care coordination outlined in part three. Financing as a case management service or as targeted case management on a fee-for-service basis has the benefit of providing funding at a level that is commensurate with the number of children who qualify and receive the service. PMPM or capitation payments provide practices with a known, predictable amount of funding that they can then deploy to add a care coordination staff person. This can add an additional resource to the practice without the practice having to establish an ongoing billing system to cover its cost. A practice with 800 children ages 0 to 3 that receives a PMPM payment of \$8 per member per month, for example, will have new funding of \$76,800 of a year, an amount that generally can provide for a full-time, on-site social worker or family specialist. That specialist’s time may be well spent and improve children’s health trajectories; but if there are 200 children who require such help, that staff person may only be able to effectively serve a portion of those in need. The investment may be sufficient to demonstrate high returns-on-investment, but it also may realize only a portion of its potential in reducing health disparities.*

Pay-for-performance payment approaches have gained popularity in recent years. In this case, regular payment rates or bonus/incentive payments may be tied to performance measures related to the clinical care process and/or outcome measures. For example, a state or MCO/ACO might pay higher rates or bonuses to high performing medical homes that perform well based on measures established to show impacts and the achievement of health goals (see part seven).

In addition, some Medicaid MCO or ACO contracts may seek to redirect some proportion of “shared savings” from successful MCO efforts — where MCOs show they have reduced costs for a specific population and deserve an incentive or bonus for doing so — into reinvesting in new efforts and innovations to produce savings. MCOs retain a share of the savings, but rather than the rest going back to the state in reduced costs, some are directed to additional MCO efforts to improve health care. There are a few instances where such “shared savings” may be achieved with a young child population, but in most instances they are achieved with adult populations. There is nothing to prevent state MCO contracts from designating a portion of any “shared savings,” from whatever population, toward advancing young child health. Again, this is a strategy that may accelerate innovation and its diffusion, creating a new focus on young children. It is only an adjunct, however, to other efforts to define and finance high performing medical homes for young children both in the state Medicaid plan and direct fee-for-service payment systems and within managed care contractual provisions.

To date, 39 states have incorporated MCOs into their Medicaid programs.

* The young child population includes a significant proportion of children with presenting health conditions that can benefit from earlier detection and treatment, but it also includes a larger population of children, whether or not they have diagnoses, who have risks and conditions which, if they do not change, will result in future health problems.

Value-Based and Performance-Based Purchasing for Children

Medicaid financing is complex, and it is made more complex by the fact that Medicaid not only covers children, but also low-income adults ages 19-64, persons with disabilities, and seniors age 65 and older with varying needs. This means that many individuals with complex medical and chronic conditions involving a wide range of treatments and very high costs, particularly seniors and persons with disabilities, are a focus of Medicaid fiscal strategies. Many of the new and alternative payment models are focused on persons with chronic conditions and complex and high-cost medical needs, particularly those related to “value-based” and performance-based payment approaches. The ACO model, pushing provider networks beyond traditional MCOs, is designed to promote care integration and provide financial incentives (e.g., shared savings) for improved outcomes.

As they seek to develop alternative strategies and care and treatment options to meet patient health care needs with lower medical costs and involvement, states and contracting MCOs/ACOs generally focus on high-cost and medically complex populations[†], and not on children with health care needs and costs in the normal range.⁶ When it comes to children, a much larger share of Medicaid expenditures are for primary care services and relatively low-cost ambulatory treatment services for childhood illness and injury.

Since high-value health care is generally defined as that which produces the best outcomes at the lowest costs, people with medically complex conditions and high costs should not be the only focus.

However, since high-value health care is generally defined as that which produces the best outcomes at the lowest costs, people with medically complex conditions and high costs should not be the only focus. As described by Bailit in one of the first analyses of value-based care from a child health perspective, “The profound difference in health care objectives and services for children and adults and the strong link between childhood experiences and adult health and health care costs has not been recognized in the design and implementation of value-based payment models.”⁷

The seminal work on value-based payments emphasized that “value” must not be measured in terms of equivalent or better quality of care and population-based outcomes and reduced or contained per-capita costs of care.⁸ Still, much of the focus in payment systems innovations based on providing “value-based” care (paying for outcomes and not services) has been on achieving immediate cost containment or reductions. If further efforts in this field are to realize their potential with young children, they must emphasize that paying for value includes the value of long-term health benefits for young children apart from any immediate cost offsets to medical services.⁹

Managed Care Contracts and High Performing Medical Homes for Young Children

As discussed above, most children covered by Medicaid receive services under state contracts with MCOs, with the contract providing state requirements and payment structures for the MCO. The MCO then contracts with providers to deliver services. Whether or not they are delineated specifically in the contracts, children must receive the EPSDT benefit and its full range of services. Medicaid also requires patient choice (e.g. more than one managed care plan, unless states secure a waiver for their contracting)

[†] The most commonly referenced opportunities for shared savings are reducing emergency room visits and hospitalizations with better management of conditions for children with asthma or high levels of medically complexity.

and a network of service providers capable of meeting the service needs of the covered population.

Most current state Medicaid contracts with MCOs provide incentives to contain or reduce health care costs—through capitated payment rates, performance-based (or value-based) payments, or rate negotiations with service providers and prior authorizations for or limitations on services (to reduce overuse of services). MCOs also can in turn create incentives to providers. These relationships are illustrated in Figure 13.

Increasingly state contracts with MCOs are based upon a capitation rate for at least some services and populations, based on historical use and cost for the population being served. Depending on how the contract is structured, the MCO assumes some or all financial risk if its payments exceed the capitated payment — and the MCO retains at least a part (shared savings) of the amount below that capitated level. Federal law allows states to provide up to 5 percent above the capitated rate for incentive payments, which can be used to reward plans for meeting specified outcomes and priorities. Managed care contracts often offer greater flexibility in providing alternative services than is allowable under direct fee-for-service payment systems.

With respect to high performing medical homes for young children, the state Medicaid contract with the MCO requires specific state direction for advancing high performing medical homes and state oversight for doing so, as shown in Figure 13.

Medicaid Contract Language to Ensure Coverage under EPSDT

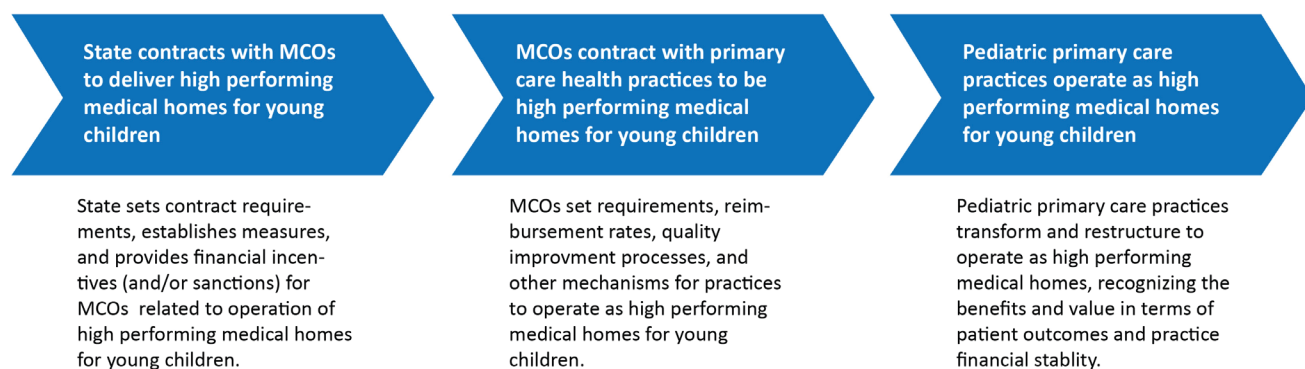
As discussed above, in managed care and accountable care arrangements, the state must establish contracts that specify the scope of services covered, the diagnoses, and authorizations required to cover the services, the duration and intensity of the services eligible for payment, the documentation required to receive payment, payment rates, and terms for any incentives based on performance or quality. Thus, state Medicaid managed care contracts must specify and provide financial incentives for the MCOs/ACOs to increase the proportion of children who are provided primary, preventive, and developmental services under a high performing medical home.

Today, most Medicaid managed care contracts set out requirements for securing an adequate number of providers of care, providing core covered services in the Medicaid plan, and reiterating the requirements under EPSDT for children. Often, they do not go much further in setting expectations and requirements for child health, and particularly for primary and preventive health services for young children.

This starts with Medicaid managed care contracts distinguishing the financing of primary and developmental services for young children from other parts of the managed care contract and developing financial incentives to MCOs to increase their expenditures/investments in such care, not reduce or contain them. State contracts with MCOs also should specify performance and reimbursement terms for high performing medical homes for young children, as well as additional services. As described in part two of this sourcebook, this

State Medicaid managed care contracts must specify and provide financial incentives for MCOs/ACOs to increase the proportion of children who are provided primary, preventive, and developmental services.

Figure 16. State, Managed Care Organization, and Provider Relationships in Contracting



would include well-child visits that identify and respond to early childhood developmental, behavioral, and social determinants of health and offer some level of care coordination to address them. Key elements to address in MCO contracts include:

- Performance goals and incentives for increasing the proportion of well-child visits, which meet the *Bright Futures* guidelines in terms of content and timing.
- Definitions for high performing medical homes for young children, with performance expectations and measures.
- For designated high performing medical homes, structuring of payments and incentives to cover the cost of augmented well-child visits, additional screening, practice staff focused on development, and/or intensive care coordination. This may be built into the managed care contract as part of or beyond the capitated payment for other services.
- Measures and quality improvement/performance improvement projects designed to increase the quality of well-child visits and the availability of high performing medical homes.
- Opportunities for MCOs to use a portion of shared savings from other efforts that reduce Medicaid costs to make further investments in primary practices engaged in providing enhanced well-child care and to advance other strategies to improve healthy development for the young child population.
- Language specifying that “medical necessity” is defined for young children to include preventing, ameliorating, and addressing risks and conditions related to child development. Based on individual determinations of medical necessity, this might include services such as developmental interventions, parent support programs, parent-child dyadic mental health therapy, and other early childhood mental health interventions.

Contract purchasing specifications proposed by the George Washington University describe considerations in making coverage and medical necessity determinations about treatment under EPSDT.^{10 11} The model purchasing specifications were designed to guide Medicaid agencies in developing strong and

effective contracts under managed care arrangements. They suggest that in making a coverage determination, Medicaid managed care contracts should require contractors to consider the following evidence and information, if offered on behalf of the enrolled child:

- Recommendations of the provider treating the enrolled child for whom the coverage determination must be made;
- Clinical evidence of the health status and needs of the child;
- Evidence and information that is provided by the child or child's family or caregiver;
- Opinions of medical, dental and other health care practitioners who are experienced in the treatment of children with similar mental or physical illnesses or conditions;
- Professional standards of medical, dental and other health care practice related to the care of children, as reflected in: 1) scientific literature published in peer-reviewed journals; 2) the results of clinical trials relevant to pediatric care; 3) government-sponsored studies; 4) professional consensus statements; and 5) other sources of valid and reliable evidence regarding the pediatric standard of care;
- Opinions of, and evidence supplied by, qualified individuals who are involved in the care of the enrolled child and who are affiliated with publicly-supported agencies, programs, or providers delivering health services to children residing in contractor's service area; and
- Provisions of an Individualized Education Program (IEP) or an Individualized Family Services Plan (IFSP) under the Individuals with Disabilities Education Act (IDEA).

Consistent with the purposes and design of the EPSDT benefit for children, the model purchasing specifications also recommend that state Medicaid managed care contracts specify that the contractor shall not deny, terminate, reduce or exclude coverage in part or in whole of an item or service covered for an enrolled child because the item or service sought is: 1) required to treat a condition rather than an illness or injury; 2) not expected to result in the restoration or achievement of normal functioning; 3) experimental, unless the service is available only through a clinical trial, or is not a generally accepted practice or procedure among pediatric specialists; 4) identified in a plan of care developed by another public agency, in an IEP or IFSP, or provided in a school setting; or 5) mandatory because of a failure of the family or caregiver of the enrolled child to ensure that the child has complied with a recommendation or prescription of the child's treating provider.

Medicaid Administrative Claiming

In addition to financing services to eligible recipients, Medicaid also provides federal matching funds (i.e. federal financial participation-FFP) for certain administrative activities related to Medicaid.¹² This includes field staff time in eligibility determinations, outreach, claims processing, reporting and documentation, and overseeing contracts, including managed care. Most administrative claiming is not at the states' FFP rate for medical care (which varies for states between a 50 percent and 70+ percent federal match, based on a formula that reflects the state economy) (42 CFR 1007.19) but at a 50-50 federal-state matching rate. (42 CFR 433.15(b)(7)). For a few activities, matching is 75-25 federal-state. (See 42 CFR 433.15(b)(1)-(6) for higher matching rates).

Medicaid administrative claiming can be used for implementing new Medicaid operational approaches,

training and supporting practitioners in their use, and establishing the infrastructure necessary for service providers to operate.¹³ It is mandatory to cover primary, preventive, and developmental services as medical services and not under administrative claiming, but there are some features that can be financed best through administrative claiming (e.g. monitoring the effective implementation of policy, training providers in Medicaid-specific knowledge and skills, and data and information systems). This includes training and supporting practices in converting to becoming high-performing medical homes and developing the reporting and management capacities to do so. It also includes the work in identifying and training and supporting other community service providers so medical homes make effective referrals to services available in the community. For example, this might involve training for case managers, individuals who develop and coordinate person-centered care planning, and primary care practitioners. (Costs incurred by providers to meet continuing education and advanced professional training requirements cannot be claimed as a Medicaid administrative spending.)

To move to the pediatric standard of care defined in *Bright Futures* will require states to develop Medicaid reimbursement systems, supported by clear and strong service definitions, billing codes, service provider guidelines, contracts, and measurement approaches.

Notably, administrative claiming may not include: funding for a portion of general public health initiatives that are made available to all persons, such as public health education campaigns, the overhead costs of operating a provider facility, duplicate payment for activities that are already being offered or should be provided by other entities or paid through other programs, and/or supplantation of funding obligations from other federal sources. Best practices for administrative claiming through contracting include: strong memoranda of understanding between agencies, clear documentation of services provided, and justification as being “proper and efficient” for the state’s administration of its Medicaid state plan. (Section 1903(a)(7))

State Title V Maternal and Child Health Block Grant programs often are able to provide or contract for administrative services related to children in Medicaid (e.g., related provider training, system coordination, measurement) and to bill for administrative costs. A number of states have developed specific contracts with their Title V agencies and/or other community entities to engage in such activities. Federal law requires interagency agreements (typically memoranda of understanding) between Medicaid and Title V programs, particularly to ensure proper administration of the EPSDT benefit. Administrative claiming is one element states may include in such agreements.

References

- 1 Coker TR, DuPlessis HM, Davoudpour R, et al. Well-child care practice redesign for low-income children: The perspectives of health plans, medical groups, and state agencies. *Academic Pediatrics*. 2012;12(1):43-52.
- 2 Centers for Medicare and Medicaid Services (CMS). Medicaid Managed Care Quality. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/index.html>. Accessed August 3, 2018.
- 3 Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. *Health Affairs*. 2008 May;27(3):759-769.
- 4 Centers for Medicare and Medicaid Services. State guide to CMS criteria for Medicaid managed care contract review and approval. January 20, 2017. <https://www.medicaid.gov/medicaid/managed-care/downloads/mce-checklist-state-user-guide.pdf>. Accessed July 14, 2018.
- 5 Rosenbaum S, Schmucker S, Rothenberg S, Gunsalus R, Beckerman JZ. Medicaid payment and delivery system reform: Early Insights from 10 Medicaid expansion states. *Commonwealth Fund Issue Briefs*. 2017;2017:1-15.
- 6 Bailit M, Houy M. Value-Based Payment Models for Medicaid Child Health Services. United Hospital Fund. July, 2016.
- 7 Bailit M, Hargunani D, Taylor E. Challenge Guide: Payment reform to address social determinants of health for children. Paper prepared for AcademyHealth, Child and Adolescent Health Measurement Initiative, and Children's Hospital Association. April, 2018.
- 8 Berwick et al. Op cit.
- 9 Bachman SS, Comeau M, Long TF. Statement of the problem: health reform, value-based purchasing, alternative payment strategies, and children and youth with special health care needs. *Pediatrics*. 2017 May 1;139(Supplement 2):S89-98.
- 10 George Washington University Medical Center, Center for Health Services Research and Policy. Optional purchasing specifications related to pediatric services: A user's guide. 2002. Available at: https://publichealth.gwu.edu/departments/healthpolicy/CHPR/newsps/peds-user-guide/Pediatric_Guide.pdf. Accessed August 1, 2018.
- 11 George Washington University Medical Center, Center for Health Services Research and Policy. Optional purchasing specifications for child development services in Medicaid managed care. Center for Health Policy Research. Paper 4. 2000. Available at: https://hsr.himmelfarb.gwu.edu/sphhs_policy_chpr/4/. Accessed August 1, 2018.
- 12 Centers for Medicare and Medicaid Services. Medicaid Administrative Claiming. Available at: <https://www.medicaid.gov/medicaid/finance/admin-claiming/index.html>. Accessed July 14, 2018.
- 13 Centers for Medicare and Medicaid Services. Questions and answers: Administrative claiming related to training and registry costs. July 8, 2015. Available at: <https://www.medicaid.gov/medicaid/finance/downloads/qa-training-registry-costs-071015.pdf>. Accessed July 14, 2018.



K. Johnson and C. Bruner. A Sourcebook on Medicaid's Role in Early Childhood: Advancing High Performing Medical Homes and Improving Lifelong Health. Child and Family Policy Center. October 2018.

Part Seven

Measuring Performance and Progress toward High Performing Medical Homes and Better Outcomes

Part Seven / Key Takeaway Messages

- States have responsibility for reporting EPSDT performance, particularly on the use of medical and dental preventive visits. Most states have not reached the 80 percent performance goal for all children or for young children. States have opportunities to improve EPSDT performance and the quality of data used to monitor performance.
- The CMS has defined a core child set of measures for Medicaid and CHIP that focus primarily on monitoring quality using key indicators of the care process. Even though all states will be required to report quality measures in the child core set beginning in FFY 2024, many states do not yet report on all of the measures. In 2018, 11 of the 26 measures relate to young children (0-5). A substantial proportion of states are performing below the national average in terms of well-child visits in the first 15 months of life and annual visits in the third, fourth, fifth, and sixth year of life.
- A set of measures specifically designed to monitor high performing medical homes for young children is suggested in this sourcebook. These can be used under fee-for-service, managed care, or other financing arrangements for identifying and incentivizing such performance. The measures build on the CMS child core set, with additional measures that relate specifically to the performance of medical homes for children in Medicaid and CHIP.
- States have an opportunity to advance measure alignment and shared accountability across health and related programs. For example, creating a common, shared set of early childhood measures across Medicaid, Medicaid managed care, Title V Maternal Child Health Block Grant, and federal home visiting programs might help to drive program performance and practice quality improvement, as well as improved outcomes, for young children and their families.
- States also need to have monitoring systems that go beyond examining a core set of measures collected for all enrollees and encounters to more detailed reviews of a representative sample of cases (e.g. chart reviews) that determine that services receiving reimbursement are meeting the standards set for them as high performing medical homes.

Measuring EPSDT Program Performance (416 Data)

Measuring program performance is a central activity in Medicaid, CHIP, and most other federal programs. CMS collects information from state Medicaid and CHIP programs through an annual EPSDT report using Form CMS-416.¹ The resulting data are often referred to as 416 data. These data represent the most complete source of information available on the provision of primary services to children under Medicaid and do so in a manner that looks specifically at Medicaid enrollment and provision of services by child age.

States must report the following 416 data to CMS on an annual basis: 1) number of children provided child health screening service (i.e., well-child visits provided according to a state's EPSDT periodicity schedule), 2) number of children referred for corrective treatment, 3) number of children receiving dental services, and 4) state results in attaining goals set under section 1905(r) of the Social Security Act. (The goal to screen 80 percent of eligible children was enacted in 1989.) Other information is collected on the Form CMS-416, including: the total unduplicated number of children under age 21 enrolled in

Medicaid or CHIP Medicaid expansion by child age, the periodic visit schedule, and the number enrolled in managed care. Overall, CMS-416 collects 10 types of data (see text box), with additional detail on certain topics such as dental services. Notably, states do not have to report on the CMS-416 regarding general developmental screens or the required separate vision and hearing screenings. Data are reported for seven child age groups (i.e. infants under 1 year, toddlers 1-2 years, preschoolers 3-5 years, school-age children 6-9 years, early adolescents 10-14 years, adolescents 15-18 years, and youth 19-20 years). These data must include services reimbursed directly by the state under fee-for-service and those financed through managed care or other payment arrangements.

To understand program performance, two distinct summary rates are reported. The 416 data report includes a “screening ratio” that reflects the number who received an EPSDT well-child screening visit adjusted for the expected number of visits, based on months of enrollment and periodicity schedule. The report also includes a “participation ratio” that reflects the total number of eligible children who received at least one EPSDT well-child screening visit during the year. These vary by state, with the screening ratio more likely to be high for children ages 0-5. Since the periodicity schedule varies from state to state and the screening ratio is adjusted to reflect expected visits based on the periodicity schedule, cross-state comparisons are less meaningful.

Many have raised concerns over the past 30 years about the quality of the information reported on EPSDT Form 416, particularly the data on referrals. Concerns have included inconsistencies with data reporting, data inaccuracies, and limited data collection.² At the same time, many states have improved the collection and timely reporting of these data^{3 4 5} and CMS has implemented procedures to improve data quality in recent years. Every state has an opportunity to further improve and use these data. For example, conducting record reviews, improving reports from managed care organizations, providing augmented provider guidance or education, and providing incentives have been used to improve the rates of completed well-child visits and reporting about such visits.⁶

Data from Form CMS-416 represent the most complete source of information on the provision of primary services to children under Medicaid.

Despite an increase in participation between 2006 and 2013, the data indicate persistent underutilization and/or underreporting of EPSDT well-child visits. Most states did not meet the national goal for 80 percent participation for years between 2006 and 2013.⁷ The national participation ratio for all ages improved from 56 percent in 2006 to 63 percent in 2013 but was back to 58 percent in FFY 2015 and FFY 2016.⁸

These data also can help us understand variations in state performance. The map in Figure 7 (see part one) offers an example of EPSDT participation ratio data by state for toddlers ages 1 and 2. The map shows that for this age group only 20 states met or exceeded the 80 percent EPSDT performance standard on this measure. The nation fell short of the performance goal, with only 77 percent of toddlers enrolled in Medicaid having even one reported EPSDT well-child visit in FFY 2016.

Continuing to collect and improve EPSDT program data is important, despite the introduction of other quality-oriented measurement sets. EPSDT 416 data report on how many children of what ages participated in Medicaid, how many preventive well-child visits were financed by Medicaid, states’ schedules for visits, and whether children are receiving any or an appropriate number of visits. They indicate whether

Table 6. Medicaid/CHIP Core Set of Children's Health Care Quality Measures for (Child Core Set) 2018

Measure Steward	Measure Topic (Italics indicate measure related to health of young children prenatal to 5)
Domain 1: Primary Care Access and Preventive Care	
NCQA	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents (WCC-CH)</i>
NCQA	Chlamydia Screening in Women Ages 16-20 (CHL-CH)
NCQA	<i>Childhood Immunization Status (CIS-CH)</i>
CMS	Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH)*
NCQA	<i>Well-Child Visits in the First 15 Months of Life (W15-CH)</i>
NCQA	Immunizations for Adolescents (IMA-CH)
OHSU	<i>Developmental Screening in the First Three Years of Life (DEV-CH)</i>
NCQA	<i>Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34-CH)</i>
NCQA	Adolescent Well-Care Visits (AWC-CH)
NCQA	<i>Children and Adolescents' Access to Primary Care Practitioners (CAP-CH)</i>
Domain 2: Maternal and Perinatal Health	
CDC	Pediatric Central Line-Associated Bloodstream Infections (CLABSI-CH)
TJC	PC-02: Cesarean Birth (PC02-CH)
CDC	<i>Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH)</i>
CDC	<i>Live Births Weighing Less Than 2,500 Grams (LBW-CH)</i>
NCQA	<i>Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)</i>
OPA	Contraceptive Care — Postpartum Women Ages 15-20 (CCP-CH)
OPA	Contraceptive Care — All Women Ages 15-20 (CCW-CH)*
Domain 3: Care of Acute and Chronic Conditions	
NCQA	Asthma Medication Ratio: Ages 5-18 (AMR-CH)*
NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)
Domain 4: Behavioral Health Care	
NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)
NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6-20 (FUH-CH)
NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)
NCQA	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)
Domain 5: Dental and Oral Health Services	
DQA (ADA)	Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk (SEAL-CH)
CMS	<i>Percentage of Eligible Who Received Preventive Dental Services (PDENT-CH)</i>
Domain 6: Experience of Care	
NCQA	<i>Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H — Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH)</i>

2018 Updates to the Child and Adult Core Health Care Quality Measurement Sets available at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib111417.pdf>.

* Measure was added to the 2018 Child Core Set.

CDC = Centers for Disease Control and Prevention; CHIP = Children's Health Insurance Program; CMS = Centers for Medicare & Medicaid Services; DQA (ADA) = Dental Quality Alliance (American Dental Association); NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; OHSU = Oregon Health and Science University; OPA = U.S. Office of Population Affairs; TJC = The Joint Commission.

states are meeting the national goal for 80 percent participation. If better and more complete data were collected and reported by states, the 416 reports also could help to monitor referrals and managed care enrollment.

Several actions are recommended to improve state collection and reporting of EPSDT 416 data. First, 416 data reporting should continue as a requirement. Second, through combined federal and state action, record reviews for a sample of children should be conducted to evaluate data quality. One key opportunity is to begin by sampling with young children ages 0 to 3 years for whom more frequent preventive visits are recommended. Third, CMS established the Technical Assistance and Analytic Support Program to support states' child health care quality measurement and improvement efforts, and this or a similar mechanism should be used to support states' efforts to improve 416 data reporting.

Measuring Quality in Medicaid and CHIP

Quality improvement and measurement activities can accelerate practice change, focus on priorities, and monitor improvement in outcomes. States such as Oregon and Minnesota have demonstrated the role of quality improvement and measurement activities for increasing developmental screening rates. In a child health system in Cincinnati, adopting a pediatric primary care service bundle and using quality improvement approaches led to significant improvements in practice — from 58 percent to 92 percent of visits where the full bundle of preventive services was received for patients 0 to 14 months of age, with sustained improvement for over 1 year.⁹ As discussed in part one, much remains to be done to ensure a high performing medical home and quality care for young children in Medicaid.

Quality improvement and measurement activities can accelerate practice change, focus on priorities, and monitor improvement in outcomes.

Quality improvement begins with setting goals and defining measures. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) required the U.S. Department of Health and Human Services to identify and publish a core measure set of children's health care quality measures for voluntary use by state Medicaid and CHIP programs. As a result, a core set of health care quality measures for children in Medicaid and CHIP (referred to as the Child Core Set) were established in 2010 to guide federal and state efforts to collect, report, and use a standardized set of measures to improve the quality of care provided to children covered by Medicaid and CHIP. As shown below, in 2018 the Child Core Set has 26 measures which address six domains of care. A majority (11) of the measures are relevant to the health of young children (0-5).

Figure 8 (see overview) maps the variation in states' performance on the Medicaid-CHIP child core measure for preventive visits among infants and toddlers—the percentage of children receiving six or more visits by 15 months. The national median for this measure was 61 percent, and states' performance ranged from 29 to 83 percent. Ensuring that children receive well-child visits according to the recommended schedule represents minimum performance for the pediatric medical home. These data point to an opportunity to increase the performance of medical homes for young children, with state agencies implementing Medicaid and CHIP playing a central role in financing, incentivizing, and contracting to support improvements.

Table 7. Alignment of Select Measures for Monitoring Child Health Prenatal to 5 Years

	Core Set of Child Health Measures for Medicaid and CHIP	Health care Effectiveness Data and Information Set (HEDIS)	Title V MCH Grant National Measures	Maternal, Infant, and Early Childhood Home Visiting (MIECHV)
Preterm birth	Low birthweight		✓	✓
Prenatal care visits	✓	✓	✓	
Postpartum care visits	✓	✓		✓
Postpartum contraceptive care	✓			
Breastfeeding			✓	✓
Maternal depression screening and follow up	Behavioral health assessment	✓		✓
Well-child visits first 15 months	✓	✓	Medical home	✓
Well-child visits 3, 4, 5 and 6 years	✓	✓	Medical home	✓
Immunization status	✓	✓	✓	
Access to primary care	✓	✓	Medical home	
Developmental screening	✓		✓	✓
Lead screening		✓		
Preventive dental visit	✓	✓	✓	
Safe sleep			✓	✓
Tobacco use/cessation	Adult set	✓	✓	✓
Child injury			✓	✓
Emergency visits	✓	✓		✓
Weight assessment and counseling	✓	✓	✓	
Children with special health care need (CSHCN)			✓	
Experience of care (children and CSHCN) - CAHPS® 5.0H				
Insurance coverage	(assumed)	(assumed)	✓	✓

Sources:

- Medicaid-CHIP: <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html> Child health quality core measurement set for 2018. <https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-child-core-set.pdf> Maternity/perinatal core measurement set: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-maternity-core-set.pdf>
- Health Plan Employer Data and Information Set (HEDIS): <https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/chttoolbx/measures/measure4.html> Aligned with HEDIS measures from standard set HEDIS 2018. <http://www.ncqa.org/hedis-quality-measurement/hedis-measures/hedis-2018>
- Title V Maternal and Child Health Block Grant program: <https://mchb.tvisdata.hrsa.gov/PrioritiesAndMeasures/NationalPerformanceMeasures>
- Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program: <https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting/home-visiting-program-technical-assistance/performance-reporting-and-evaluation-resources>
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H — Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH) <http://www.ncqa.org/hedis-quality-measurement/data-reporting-services/cahps-5-0-survey/cahps-5-0h-survey> Also see: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/cahpsbrief.pdf> And CAHPS set for Children with Chronic Conditions <https://www.ahrq.gov/cahps/surveys-guidance/item-sets/children-chronic/index.html>

States vary in their reporting on specific measures. Since the release of the Child Core Set in 2010, an increasing number of states are reporting data to CMS. For FFY 2016, all 50 states voluntarily reported at least one Child Core Set measure, with 45 reporting at least half of the measures.¹⁰ Some states have found greater success with reporting on the Medicaid/CHIP core measures. State strategies associated with quality measure reporting and performance include: contractual requirements and technical assistance to Medicaid health plans; public reporting on health plan performance; incentives tied to health plan performance; NCQA accreditation requirements for health plans, and working closely with health plans to avoid the need for corrective action.¹¹ Filling the gap between Medicaid/CHIP core measures and the HEDIS measures has been a challenge in some states. Many states also have challenges reporting on the fee-for-service Medicaid populations or services.

Notably, as part of 2018 federal law changes in the ACCESS Act, states will be required to report on all of the Child Core Set measures beginning in FFY2024.¹² With nationwide reporting, it will be easier for state agencies and child advocates to monitor Medicaid and CHIP program quality and identify areas for improvement.

Measuring Quality and Performance of Pediatric Medical Homes for Young Children in Medicaid

State Medicaid agencies increasingly emphasize accountability, quality, and outcomes. Table 2 in part one of this sourcebook provides a set of measures that can be used to monitor the performance of pediatric medical homes for young children in Medicaid. The suggested measures combine key early childhood measures from the CMS child core set which may already be routinely collected. In addition, Table 4 (in part two) suggests measures that may require new data collection, including medical records review or other approaches. For example, despite the CMS child core set already containing a measure for developmental screening, additional information would need to be collected to monitor use of the CSHCN validated screening tool, emerging SDOH screening tools, and use of pre-visit tools such as the Well-Visit Planner.

State Medicaid agencies increasingly emphasize accountability, quality, and outcomes. This sourcebook provides a set of measures that can be used to monitor the performance of pediatric medical homes.

In addition, this sourcebook has emphasized the importance of screening for and responding to social determinants of health (household materials well-being, parental physical and psychological well-being, family social well-being, and parent-child relational well-being). There is not yet a widely adopted tool for screening for social determinants, but a Technical Working Group for the Child and Adolescent Health Measurement Initiative has developed an initial screening tool for use and adaptation, based on a review of current methods in use.¹³ States can advance such screening for social determinants of health by providing coverage while setting parameters on what should be included in those screenings.

Measurement to Promote Shared Accountability

Use of quality and performance measures also can be part of shared accountability across services and systems. Table 6 shows the alignment across four important national measurement sets, including those measures related to prenatal, infant, and early childhood health as defined in the: 1) Medicaid-CHIP

child core measurement set, 2) Health Care Effectiveness Data and Information Set (HEDIS), 3) Title V Maternal and Child Health Services (MCH) Block Grant national performance and outcome measures, and 4) Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV). Most of these measurement topics are represented in the Medicaid/CHIP child core measure set defined by CMS for use by states, plans, and providers. Half of the topics are part of HEDIS, which is used by more than 90 percent of America's commercial and Medicaid health plans to measure performance. Most of these measurement topics are among the Title V Maternal and Child Health Block Grant national performance measures and national outcome measures. In addition, many of the topics related to health prenatal to 5 are among the national MIECHV performance measures for home visiting programs.

States have an opportunity to define a set of early childhood health measures, for which data can be collected and used to monitor the performance in primary care, home visiting, and other early childhood programs.

These topics also are reflected in various other maternal and child health measurement sets. Many additional clinical quality and performance measures can be found in the Pediatric Quality Measures Program (PQMR) at the Agency for Healthcare Research and Quality^{14 15} and the Patient Reported Outcomes Measurement Information System (PROMIS) launched by the National Institutes of Health. The PQMP program authority extended and funding levels increased through FFY 2027 under the HEALTHY KIDS and ACCESS Acts. For more information on these and other child health measures, visit the Maternal and

Child Health Measurement Research Network portal and compendium of measures at <http://www.child-healthdata.org/browse/mchmeasurement>.

States have an opportunity to define a set of early childhood health measures, for which data can be collected and used to monitor the performance in primary care, home visiting, and other early childhood programs. Whether looking at results across systems of care or increasing shared accountability of programs, the measurement topics shown in Table 6 are a suggested place to begin.

References

- 1 Centers for Medicare and Medicaid Services Instructions for Completing Form CMS-416: Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participation Report Available at: <https://www.medicaid.gov/medicaid/benefits/downloads/cms-416-instructions.pdf>. Accessed July 10, 2018.
- 2 U.S. General Accountability Office. Medicaid: Concerns remain about sufficiency of data oversight of children's dental services. Available at: <https://www.gao.gov/products/GAO-07-826T>. Accessed July 10, 2018.
- 3 National Academy for State Health Policy. Reporting and Data Collection [in Medicaid and CHIP] 2013. <https://nashp.org/reporting-data-collection/>. Accessed July 10, 2018.
- 4 Florida reporting on improvements. Available at: http://www.fdhc.state.fl.us/Executive/Communications/Press_Releases/archive/docs/2016_2017/Apr/pressrelease416.pdf. Accessed July 10, 2018.
- 5 Louisiana HealthCare Connections use of technology to improve CMS 416 data reporting. Available at: http://ldh.la.gov/assets/docs/Proposals2014/LHC/Section_M_Early_Periodic_Screening_Diagnosis-and-Treatment.pdf. Accessed July 10, 2018.
- 6 Office of Inspector General. Most Medicaid children in nine states are not receiving all required preventive screening services. (OEI-05-08-00520) U.S. Department of Health and Human Services, May 2010. Available at: <https://oig.hhs.gov/oei/reports/oei-05-08-00520.pdf>. Accessed July 10, 2018.
- 7 Office of Inspector General. Recommendation Followup Memorandum Report: CMS needs to do more to improve children's utilization of preventive screening services, OEI-05-13-00690. U.S. Department of Health and Human Services. November 12, 2014. <https://oig.hhs.gov/oei/reports/oei-05-13-00690.pdf>. Accessed July 10, 2018.
- 8 Centers for Medicare and Medicaid Services. Annual EPSDT Participation Report. Form CMS-416. Fiscal year: 2016. U.S. Department of Health and Human Services. Accessed June 20, 2018.
- 9 Samaan ZM, Brown CM, Morehous J, et al. Implementation of a preventive services bundle in academic pediatric primary care centers. *Pediatrics*. 2016 Mar;137(3):e2014-3136.
- 10 Centers for Medicare and Medicaid Services, Medicaid/CHIP Health Care Quality Measures Technical Assistance and Analytic Support Program. The state of children's health care quality in Medicaid and CHIP: State strategies to promote reporting and performance. U.S. Department of Health and Human Services, March, 2016.
- 11 Centers for Medicare and Medicaid Services, Medicaid/CHIP Health Care Quality Measures Technical Assistance and Analytic Support Program. Quality of care for children and adults in Medicaid and CHIP: Overview of findings from the 2016 child and adult core sets. U.S. Department of Health and Human Services, September 2017.
- 12 Whitener K. HEALTHY KIDS and ACCESS Acts: Summary of key provisions impacting children. Georgetown University Health Policy Institute, Center for Children and Families. 2018. Available at: <https://ccf.georgetown.edu/wp-content/uploads/2018/03/Healthy-Kids-Access-Acts-FINAL-1.pdf>. Accessed August 30, 2018.
- 13 Bruner et al. Op cit. 2018.
- 14 Agency for Healthcare Research and Quality. Pediatric Quality Measures Program. U.S. Department of Health and Human Services. Available at: <https://www.ahrq.gov/pqmp/index.html>. Accessed June 19, 2018.
- 15 Agency for Healthcare Research and Quality. Child Clinical Preventive Services. U.S. Department of Health and Human Services. January 2018. Available at: <http://www.ahrq.gov/pqmp/measures/child-clinical-preventive-services.html>. Accessed June 20, 2018.

Appendices

Appendix A. Medicaid Enrollment and Spending Data by State

Appendix B. State EPSDT Periodicity Schedules for Young Children, By State, 2016

Appendix C. Opportunities to Improve Effectiveness of Medicaid Investments in Early Childhood

Appendix D. Health Equity and Young Children Initiative Exemplary Programs and Practices

Appendix E. Reimbursing for Office Visits and Screening, including Major Medicaid CPT (Billing) Codes for Preventive Well-Child / EPSDT Visits and Related Screening for Young Children 0 to 5

Appendix A. Medicaid Enrollment and Spending Data by State

Multiple sources of information exist regarding Medicaid and CHIP coverage of children. Data are available regarding eligibility, enrollment, utilization, and expenditures for that coverage, as well as for the extent to which children are insured. Each source of information adds to the overall picture, but they do not always align. Only multiple data sources help to answer the key questions, including: 1) what proportion of children have health coverage or are uninsured and what is the role of Medicaid/CHIP; 2) what proportion of children are covered by Medicaid (and CHIP); 3) what proportion of Medicaid beneficiaries are children and what is their share of expenditures; and 4) what are the utilization patterns for children with Medicaid/CHIP coverage? For each of these questions, variations by state, child age, and child health status (e.g., children with special health care needs) are important and relevant to this sourcebook.

Overall Health Coverage. For the question of the current coverage of children by type of health coverage (including being uninsured), there are several sources to provide information, based upon reports by adults in the household on the coverage of children. These include:

- The American Community Survey (ACS) conducted by the Census Bureau which provides annual estimates for states and counties and cities and five-year rolling averages at the census tract level.
- The National Health Insurance Survey (NHIS) conducted by the National Center for Health Statistics, Center for Disease Control and Prevention, US HHS, which provides estimates of insurance, health status, service utilization, and other factors.
- The National Survey of Children's Health (NSCH) conducted by the Census Bureau with sponsorship of the Maternal and Child Health Bureau, Health Resources and Services Administration, US HHS (most recently in 2016), which provides additional survey information and searchable data broken down by child age (e.g 0-5, 6-11, and 12-17), poverty status, and other demographic factors.

These provide information using slightly different questions (e.g., the National Health Insurance Survey is explicit about including CHIP as well as Medicaid in its questions), but generally show the number and percentage of children by private employer-sponsored, private other, Medicaid, other government (including CHAMPUS) coverage, and no coverage – over the course of a year. All provide some state-level information, although the sample size for the NSCH and NHIS is much smaller than that for the American Community Survey and subject to larger estimation errors, particularly when there is further disaggregation by age, income or disability.

Overall, these data tend to show about 40 to 45 percent of the child population being covered by Medicaid (or CHIP for NHIS), with a higher proportion of younger children and children with special health care needs or disabilities being covered. These data are particularly important for trend analysis and illustrating the shifts in types of health coverage for children over time, as shown in Figure 2 of this sourcebook, based on NHIS data.

Children and Medicaid Coverage and Expenditures. The Center for Medicare and Medicaid Services (CMS) requires states to report on both the number of individuals covered under Medicaid and the Medicaid expenditures. They are required to do so by enrollment group (children, adults, persons with disabilities, and the elderly). Additionally, the enrollment data is reported on both a monthly (point-in-time) and annual (ever during the year) basis. Some reports also include the CHIP population and break

down that population by those CHIP recipients enrolled in Medicaid (Medicaid-CHIP expansion) and those enrolled in a private or other type of plan. States are also required to submit CMS 416 data, which includes information on EPSDT enrollment and use of well-child visits services, with that data broken down further by age categories. These data are generally the best source for getting detailed information about the young child population (categories 0-1, 1-2, 3-4, etc.) in Medicaid.

There are several complicating factors in looking at various reports from CMS. First, children may be enrolled and counted in the “child” category or may be enrolled and counted under the disability category (particularly when they are SSI-eligible). Few datasets and reports capture all children, including both disability and child enrollment category. Second, reports adopt different age designations for what constitutes a child, some going only up to age 18 some going further, up to age 21 (the CMS 416 data provide this information), and some opting to go even higher for youth graduating from the foster care system. Third, some CMS information includes CHIP enrollment as well as Medicaid, but most does not. This is particularly true for those that have age breakdowns. Finally, some data represent whether a child was covered at any time during the year, while other sources identify only whether the child was covered at the point in time data were collected.

When comparing the Medicaid (or Medicaid and CHIP) enrollment data with the state population of children ages 0-17, the result shows a much higher percentage of the child population covered by Medicaid than do data from ACS, NSCH, or NHIS. Parental/adult reporting under-represents Medicaid or CHIP coverage. Moreover, enrollment does not necessarily mean active use, although young children are much more likely to use services.

When looking at 416 data or other CMS data, the point in time enrollment in Medicaid is above 50 percent for all children 0-17 overall, substantially higher for young children for a point-in-time estimate, and much higher for coverage at any time during a year. The value of other CMS data is in its ability to compare Medicaid use and expenditures by Medicaid enrollment categories and provide overall and per enrollee spending estimates.

Young Children. State 416 data reported to CMS indicate that 60 percent of children 0-3 and 56 percent of children 3-5—a total of 13.8 million young children 0-5—were enrolled in Medicaid some time during FFY2016. MACPAC reports from CMS data suggest that two-thirds of young children are covered at some time during the year under Medicaid and CHIP.

The value of the 416 data, in particular, is in providing information on breakdown by child age and on primary and preventive care visits. The age breakouts of 0-1 and 1-2 cover the 0-3 population, as well as population 0-5. These data also can show that, despite federal mandates, not all infants 0-1 year had a whole year of coverage.

The NSCH data allows for breakdowns by child age (0-5) and also by parental income level, child race/ethnicity, child health status, and other information (e.g. living in an unsafe neighborhood, living with a mother in poor or fair mental health, etc.) that can further help describe the population served by Medicaid in comparison with those covered under other programs or uninsured. However, while the sample size of the NSCH allows for substantial disaggregation at the national level, can provide only some limited data at the state level.

Children with Special Health Care Needs. Drawing from NSCH or NHIS data, reports indicate 48 percent of children with special health care needs are covered under Medicaid. From those data sources,

the rate of coverage of children with special health care needs is substantially above the rate of coverage of children overall. There are several reasons that the rate of coverage of children with special health care needs should be higher under Medicaid than for other children: 1) children receiving SSI disability coverage are automatically eligible for Medicaid; 2) the Family Opportunity Act enables states to cover children with special health care needs above current categorical eligibility levels for Medicaid and the medically needy program also may cover such children; and 3) the prevalence of special needs is somewhat higher among low income populations and also can affect household employment and earnings, with a parent more likely to spend time in the child's caregiver role as opposed to the paid workforce.

This sourcebook concludes that more than half of all young children are covered under Medicaid and CHIP for a portion of any given year, and that this figure is higher for children with special health care needs. This group of young children with special health care needs might include, for example, those with hereditary disorders, children with autism, and those born at very low birthweight or extremely preterm.

Summary. Although there is no single data source for all the information about the child, and young child population, served by Medicaid (and CHIP), there is sufficient data to provide both trend and comparative data to answer the questions posed at the beginning—at both the national and state levels.

Table A.1. Number and Percentage of Children Participating in Medicaid and CHIP

Location	FFY 2017	Participation and Expenditures Data for FFY 2014				
	Unduplicated Number of Children* Enrolled in Medicaid and CHIP*	Unduplicated Number of Medicaid Enrollees in Child Category**	Percent of Medicaid Enrollees in Child Category‡	Medicaid Expenditures for Enrollees in Child Category	Percent of Medicaid Spending Accounted for by Children	Medicaid Spending Per Full-Benefit Enrolled Child
United States	46,322,217	34,805,500	43%	\$89,688,187,300	19%	\$2,602
Alabama	820,611	623,600	50%	\$1,300,009,900	27%	\$2,083
Alaska	117,542	80,900	57%	\$415,448,900	29%	\$5,133
Arizona	1,018,142	817,500	49%	\$2,411,286,600	26%	\$2,972
Arkansas	602,852	382,700	44%	\$1,275,724,300	27%	\$3,372
California	6,867,227	4,630,400	32%	\$10,966,555,300	18%	\$2,500
Colorado	683,948	488,200	40%	\$992,636,500	17%	\$2,026
Connecticut	377,969	339,700	37%	\$1,148,251,800	16%	\$3,377
Delaware	121,075	89,600	40%	\$340,505,700	19%	\$3,835
DC	97,580	89,500	34%	\$397,638,800	17%	\$4,443
Florida	2,835,486	2,328,300	50%	\$4,242,608,500	21%	\$1,816
Georgia	1,553,231	1,202,600	58%	\$3,399,354,200	37%	\$2,825
Hawaii	177,631	130,200	39%	\$335,574,500	17%	\$2,577
Idaho	250,878	190,000	61%	\$422,876,700	26%	\$2,204
Illinois	1,760,638	1,310,900	40%	\$2,762,883,400	17%	\$2,108
Indiana	818,687	727,100	56%	\$1,559,214,900	17%	\$2,158
Iowa	433,933	298,200	43%	\$658,414,000	16%	\$2,217
Kansas	349,739	262,500	60%	\$698,780,300	25%	\$2,662

	FFY 2017	Participation and Expenditures Data for FFY 2014				
Location	Unduplicated Number of Children* Enrolled in Medicaid and CHIP*	Unduplicated Number of Medicaid Enrollees in Child Category**	Percent of Medicaid Enrollees in Child Category‡	Medicaid Expenditures for Enrollees in Child Category	Percent of Medicaid Spending Accounted for by Children	Medicaid Spending Per Full-Benefit Enrolled Child
Kentucky	642,364	478,900	38%	\$1,498,425,700	19%	\$3,123
Louisiana	866,716	662,500	50%	\$1,280,962,900	20%	\$1,930
Maine	169,955	130,400	36%	\$412,207,500	18%	\$3,164
Maryland	679,779	511,900	40%	\$1,576,659,600	17%	\$3,082
Massachusetts	775,071	490,400	25%	\$1,629,007,700	11%	\$3,508
Michigan	1,243,479	1,123,300	44%	\$2,674,596,900	20%	\$2,405
Minnesota	667,030	513,100	39%	\$1,815,085,800	18%	\$3,569
Mississippi	528,044	392,700	50%	\$1,013,328,600	22%	\$2,568
Missouri	712,678	571,300	53%	\$1,819,981,400	22%	\$3,187
Montana	147,793	104,700	58%	\$328,816,200	30%	\$3,132
Nebraska	223,299	165,400	59%	\$357,846,300	20%	\$2,163
Nevada	505,839	245,400	40%	\$373,565,400	17%	\$1,520
New Hampshire	112,626	70,700	40%	\$211,024,500	17%	\$2,984
New Jersey	979,727	687,800	41%	\$1,732,103,100	15%	\$2,484
New Mexico	432,841	320,000	40%	\$1,643,587,600	39%	\$5,137
New York	2,982,154	2,303,000	35%	\$6,050,883,500	12%	\$2,653
North Carolina	1,428,127	1,224,300	54%	\$2,885,527,300	24%	\$2,349
North Dakota	39,925	35,900	40%	\$156,950,800	17%	\$4,366
Ohio	1,549,162	1,235,700	41%	\$3,199,086,800	17%	\$2,591
Oklahoma	723,497	543,500	55%	\$1,485,513,200	30%	\$2,734
Oregon	618,437	396,600	36%	\$1,085,569,900	16%	\$2,783
Pennsylvania	1,589,165	1,105,800	42%	\$3,194,863,700	14%	\$2,889
Rhode Island	139,469	117,000	40%	\$392,723,000	17%	\$3,297
South Carolina	722,901	727,200	53%	\$1,414,288,600	28%	\$1,945
South Dakota	100,199	83,100	59%	\$194,170,200	25%	\$2,336
Tennessee	1,023,262	773,600	51%	\$2,431,287,100	26%	\$3,145
Texas	4,653,162	3,235,700	64%	\$9,596,860,600	31%	\$2,962
Utah	309,246	251,300	60%	\$623,799,000	29%	\$2,483
Vermont	79,684	67,500	32%	\$311,308,600	20%	\$4,612
Virginia	874,467	568,500	52%	\$1,615,969,800	22%	\$2,840
Washington	871,793	830,300	45%	\$1,634,931,700	17%	\$1,994
West Virginia	283,189	219,200	36%	\$586,430,100	17%	\$2,538
Wisconsin	709,711	571,900	40%	\$1,007,348,800	13%	\$1,807
Wyoming	50,257	55,100	64%	\$125,711,100	23%	\$2,292

Source for Federal Fiscal Year (FFY) 2017 data: MACPAC, 2017, analysis of CHIP Statistical Enrollment Data System data. Centers for Medicare and Medicaid Services (CMS) Table: Unduplicated number of children ever enrolled (as of February 15), <http://www.medicaid.gov/chip/downloads/fy-2016-childrens-enrollment-report.pdf>.

Source for Federal Fiscal Year (FFY) 2014 data: Kaiser Family Foundation estimates based on analysis of data from the 2014 Medicaid Statistical Information System (MSIS) and Urban Institute estimates from CMS-64 reports.

* CHIP-funded Medicaid enrollees are included in Medicaid enrollment counts.

** Children are generally people age 18 and younger for these purposes. Children who enrolled in Medicaid in the “child” eligibility pathway. Does not include children who enrolled in Medicaid via the “disability” eligibility pathway.

‡Children who had coverage at any time during the year, no necessarily for the full year. The difference varied by state, ranging from 18 percent in Alabama to 1 percent in Hawaii for FFY2014.

Table A.2. Percentage of Young Children in Medicaid, Data from ACS Census and CMS 416 for 2016

	Population total (ACS Census)	Number in Medicaid (ACS)	Percent of young children in Medicaid (ACS)	Number in Medicaid (CMS 416)
Birth to 3 years old	12,007,000	5,040,000	42%	7,204,729
3 to 5 years old	11,891,000	4,960,000	42%	6,620,174

Source for Census ACS data: Table HIC-3. Health Insurance Coverage Status and Type of Coverage--Children Under 18 by Age, 2013 - 2016. <https://www.census.gov/data/tables/time-series/demo/health-insurance/historical-series/hic.html>

Source for CMS 416 data: Centers for Medicare and Medicaid Services (CSM) Annual EPSDT Participation Report. Form CMS-416 data for FFY 2016 by state.

Appendix B. State EPSDT Periodicity Schedules for Young Children, By State, 2016

The map in Figure 9 shows that the EPSDT participation ratio varies by state for toddlers ages 1 and 2 and that for this age group only 20 states met or exceeded the 80 percent EPSDT performance standard on this measure. Notably, the periodic visit schedule also varies by state.

To assist readers in understanding these data and states' performance, this table shows how states' periodic visit schedules vary, particularly in comparison to the standard represented in the American Academy of Pediatrics Bright Futures periodic visit schedule for 2017. The Bright Futures schedule recommends: a newborn visit at birth; six visits for infants (at ages 3-5 days, and at 1, 2, 4, 6 and 9 months); five visits for toddlers ages 1 and 2 (at ages 12, 15, 18, 24, and 30 months); and three visits for preschoolers ages 3, 4, and 5. As noted in the body of the sourcebook, among 49 states and the District of Columbia in FFY 2016, eight states did not meet the standard for infants, and 30 states did not meet the standard for toddlers. All states met the standard for at least three visits among preschoolers ages 3-5 years.

	< 1 Year	1-2 Years	3-5 Years
American Academy of Pediatrics Bright Futures	Newborn + 6 = 7 visits	5	3
Alabama	5	4	3
Alaska	6	5	3
Arizona	7	4	3
Arkansas	6	3	3
California	7	5	3
Colorado	6	4	3
Connecticut	6	5	3
Delaware	7	4	3
District of Columbia	7	5	3
Florida	7	5	3
Georgia	7	5	3
Hawaii	6	4	3
Idaho	6	5	3
Illinois	6	5	3
Indiana	7	5	3
Iowa	6	4	3
Kansas	6	5	3
Kentucky	5	4	3
Louisiana	6	4	3
Maine	7	4	4
Maryland	6	4	3
Massachusetts	6	4	3
Michigan	7	4	4
Minnesota	5	4	3
Mississippi	6	5	3

	< 1 Year	1-2 Years	3-5 Years
Missouri	5	4	3
Montana	6	5	3
Nebraska	6	5	3
Nevada	5	4	3
New Hampshire	6	4	3
New Jersey	6	4	3
New Mexico	6	4	3
New York	6	3	3
North Carolina	3	2	3
North Dakota	NA	NA	NA
Ohio	7	5	3
Oklahoma	6	3	3
Oregon	6	5	3
Pennsylvania	6	5	3
Rhode Island	6	4	3
South Carolina	6	3	3
South Dakota	7	4	3
Tennessee	7	5	3
Texas	7	5	3
Utah	6	4	3
Vermont	7	5	3
Virginia	7	5	3
Washington	5	3	3
West Virginia	7	4	3
Wisconsin	5	4	3
Wyoming	7	4	3

Source: Johnson and Bruner analysis of CMS 416 reports for FFY 2016.

Appendix C. Opportunities to Improve Effectiveness of Medicaid Investments in Early Childhood

Key for cost impact:

- \$ No or minimal additional cost, mainly enhanced approach to service delivery
- \$\$ Some additional cost likely for additional services or providers
- \$\$\$ Major new cost, would likely require legislative budget action

Topic and Recommendation	Cost Impact	Authority
<i>Well-Child Visits and Primary Care</i>		
Structure provider or contract guidance and financing for well-child visits in line with high performing medical home design described in this sourcebook.	\$ Helps to fulfill entitlement	Existing federal Medicaid authority. This encompasses many elements described below in this chart (e.g., various types of screening, care coordination/ case management).
Use the American Academy of Pediatrics Bright Futures recommended periodic visit schedule for well child visits to structure EPSDT.	\$ Helps to fulfill entitlement	Existing federal Medicaid authority. Best done in partnership with providers and health plans.
Use differential reimbursement for high performing medical home.	\$\$ Helps to fulfill entitlement	Existing federal Medicaid authority. May require administrative action to determine characteristic, set rates, include in managed care contracts, etc.
Use differential risk-based reimbursement for well child visits.	\$\$ Helps to fulfill entitlement	Existing federal Medicaid authority. May require administrative action to determine characteristic, set rates, include in managed care contracts, etc.
Increase provider and family knowledge of the role of interperiodic screening visits in EPSDT.	\$ Helps to fulfill entitlement	Existing federal Medicaid authority.
Permit use of Medicaid to finance various approaches for augmenting pediatric primary care practice (e.g., Healthy Steps, Project Dulce)	\$ Helps to fulfill entitlement	It depends, often done under existing authority, through managed care contracts, or waivers.
<i>Care Coordination/Case Management (CC/CM)</i>		
Increase reimbursement for “intensive” child health CC/CM designed to ensure effective linkages between health, early care and education, and social services. (Or design and use tiered case management).	\$\$	May be existing Medicaid authority or, if using targeted case management need a State Plan Amendment (SPA). Need to define characteristics of intensive case management. Many approaches identified in ABCD and exemplary programs.

Topic and Recommendation	Cost Impact	Authority
Use Medicaid administrative case management category to support community-based case management/care coordination.	\$\$	May be existing Medicaid authority or, if using targeted case management need for a State Plan Amendment (SPA).
Consider use of innovations grant funding, demonstration waiver authority, or other special projects to begin implementation of emerging best practices in pediatric CC/CM.	\$\$	Would require additional authority, waiver, and/or designated funding.
Implement family-focused case management approaches.		May be existing Medicaid authority or, if using targeted case management need a State Plan Amendment (SPA).
<i>Developmental Screening</i>		
Permit separate Medicaid billing and reimbursement for developmental screening with a validated screening tool when delivered to a Medicaid enrolled young child by a qualified provider.	\$ Helps to fulfill entitlement	Existing federal Medicaid authority. Medicaid agency clarification needed on billing, billing codes, recommended screening tools, contract provisions, etc.
Permit separate Medicaid billing and reimbursement for screening of social-emotional- behavioral development with a validated screening tool when delivered to a Medicaid enrolled young child by a qualified provider.	\$ Helps to fulfill entitlement	Existing federal Medicaid authority. Medicaid agency clarification needed on billing, billing codes, recommended screening tools, contract provisions, etc.
Permit separate Medicaid billing and reimbursement for screening on Social Determinants of Health (SDOH) with an approved screening tool when delivered to a Medicaid enrolled young child by a qualified provider.	\$ Helps to fulfill entitlement	Existing federal Medicaid authority. Medicaid agency clarification needed on billing, billing codes, recommended screening tools, contract provisions, etc.
<i>Developmental Services for Young Children</i>		
Provide Medicaid financing for medical and related health services included in IDEA Individualized Family Service Plans (IFSP) for infants and toddlers birth to 3 years.	\$\$\$ Helps to fulfill entitlement	Existing federal Medicaid and IDEA authority. This should include, but not be limited to, medically necessary occupational, physical, speech/language, and mental health therapy.
Provide Medicaid financing for medical and related health services for young children with identified risks for developmental problems, based on EPSDT exams and other assessment.	\$\$ Helps to fulfill entitlement	Existing federal Medicaid authority and some states do this already. This is helpful for young children who have identified risks, without specific diagnoses, and/or with generalized developmental conditions.
Clarify reimbursement for parenting guidance, groups, and supports.	\$ Helps to fulfill entitlement	Existing federal Medicaid authority for anticipatory guidance in well-child visits. States could approve expanded and augmented approaches.

Topic and Recommendation	Cost Impact	Authority
<i>Home Visiting</i>		
Use Medicaid to finance maternal, infant, and early childhood home visiting program services.	\$\$\$	Existing federal Medicaid authority, or may this require a State Plan Amendment (SPA) or waiver, depending on state's approach. This is for home visiting programs, not just services delivered in home. Augments federal home visiting grants.
<i>Children with Special Health Care Needs</i>		
Adopt common, shared definitions from children with special health care (CSHCN) needs	\$ Not all Medicaid cost	Existing federal Medicaid authority. Build from the Title V federal definition of CSHCN. Use across health, Medicaid, managed care, newborn screening, Part C, education, and other programs and systems.
Ensure CSHCN have medical home and provide Medicaid higher level of compensation for additional time required.	\$\$	Existing federal Medicaid authority. States would need to modify reimbursement rates, provider qualification, billing codes, and managed care contracts.
Use validated, recommended CSHCN screener at Medicaid enrollment and periodically thereafter.	\$	Existing federal Medicaid authority. States would need to add to administrative rules, managed care contracts, etc.
Give prior authorization for services in plan of care and using EPSDT medical necessity individualized approach, not on service-by-service basis.	\$	Existing federal Medicaid authority. States would need to add to administrative rules, managed care contracts, etc.
<i>Early Childhood Mental Health</i>		
(as above) Permit separate Medicaid billing and reimbursement for screening of social-emotional- behavioral development with a validated screening tool when delivered to a Medicaid enrolled young child by a qualified provider.	\$ Helps to fulfill entitlement	Existing federal Medicaid authority. Medicaid agency clarification on billing, billing codes, recommended screening tools, contract provisions, etc.
Permit and encourage Medicaid billing and reimbursement for maternal depression screening with a validated screening tool when delivered to a mother of a Medicaid enrolled young child by a qualified provider.	\$ Helps to fulfill entitlement	Existing federal Medicaid authority. Maternal depression screening during pediatric visit may be billed to child's Medicaid number. Medicaid agency clarification needed on billing, billing codes, recommended screening tools, contract provisions, etc.
Approve Medicaid financing for parent-child "dyad" therapy when medically necessary for young children birth to 5 years.	\$\$ Helps to fulfill entitlement	Existing federal Medicaid authority. Requires Medicaid agency clarification in provider guidance and appropriate billing codes.

Topic and Recommendation	Cost Impact	Authority
Increase Medicaid financing for early childhood mental health consultation.	\$\$	Existing federal Medicaid authority. Needs programmatic design and partnership with state mental health agencies and community providers. Consultation for individual children in health care, child care, and other settings.
Use Medicaid to finance home visiting services specifically designed for children with social-emotional-behavioral needs.	\$\$	Existing federal Medicaid authority, or may this require a State Plan Amendment (SPA) or waiver, depending on state's approach.
<i>Early Care and Education</i>		
Authorize use of Medicaid funds to finance the time of health professionals working as child care health consultants.	\$\$	Existing federal Medicaid authority Requires action by Medicaid state agency.
Provide support from the Department of Health for training, supervising, and financing child care health consultation.	Use public health funds, not Medicaid	
Provide funding at a level adequate to make inclusive and therapeutic child care accommodations available for those children with special needs who qualify.	\$\$	Existing federal Medicaid authority.
Work with communities, child care, and therapy providers to ensure that all qualified child care providers are trained and participating in inclusive and therapeutic child care.	\$\$ Use child care and health funds, not Medicaid	
<i>Oral Health</i>		
Increase required direct referrals to dentist (beginning at age one) and use of preventive dental visits among young children.	\$ Helps to fulfill entitlement. Not all Medicaid funds.	Promoting referrals from pediatric primary care, early care and education, home visiting, and WIC providers.
Promote use of the federal online directory for Medicaid/CHIP dental providers.	\$	Required reporting to directory. Value in promoting use by families.
Monitor the number of referrals and use of preventive dental visits among young children in Medicaid.	\$	Required in CMS 416 reporting on EPSDT. Opportunity to improve data quality.
<i>Systems and Finance Changes</i>		
Support pediatric primary care transformation, with reimbursement for practices that meet defined characteristics (e.g. high performing medical homes).	\$	May be done under existing authority, innovations grants, waivers, or other demonstration projects. Also use Title V Maternal and Child Health Block Grant.

Topic and Recommendation	Cost Impact	Authority
Define how an array of personnel can work under the supervision or recommendation of a licensed professional.	\$\$	Existing federal Medicaid authority. States are financing services of community health workers, doulas, and others.
Collect, use, and report data on births and early childhood service utilization and outcomes.	\$	Existing federal Medicaid authority. Core measures set recommended.
Use financing flexibility and emerging approaches to better fund services for young children.	\$	May be existing authority or, may need a State Plan Amendment (SPA) or waiver authority. Examples include differential payments, tiered case management, value-based purchasing, and accountable care structures.
Use administrative claiming to improve systems and quality.	\$\$	Existing federal Medicaid authority.
Develop and support provider quality improvement, network development, and training approaches.	\$	May be done under existing authority, innovations grants, waivers, or other demonstration projects. Also use Title V Maternal and Child Health Block Grant.
Provide incentives for partnerships between medical/health providers and community-based organizations.	\$	May be done under existing authority, innovations grants, waivers, or other demonstration projects. Also use Title V Maternal and Child Health Block Grant.

Sources:

- Developmental services, home visiting, mental health, and child health consultation are not defined benefit categories in the federal statute; however, services have been covered by one or more states using EPSDT authority. Various provider, benefit, and financing approaches have been used.
- Existing federal Medicaid authority means that service is: a) specifically identified as covered in federal statute or regulation, b) described as covered in federal guidance or communications such as “state Medicaid director” letters, and/or c) has been approved by CMS in one or more states covering the service for children and families.

Appendix D. Health Equity and Young Children Initiative Exemplary Programs and Practices

As part of its work under the Health Equity and Young Children Initiative grant, the Child and Family Policy Center enlisted 12 leading programs in the early childhood health field to be part of a learning collaborative. The purpose of the collaboration was to have programs share their work and contribute to defining exemplary practice in the field. Several programs were multi-site initiatives and both the program's national office and a designated local program participated in the collaborative.

Between 2016 and 2018, these programs and practices met for two retreats to describe their efforts, define common elements, and explore more deeply their role in providing care coordination, community linkages, engaging families, and addressing issues of equity and diversity. Summaries of the retreats are available on the Child and Family Policy Center's health equity web pages (https://www.cfpciowa.org/en/issues/health_equity/). These summaries contributed to the National Advisory Panel's framework paper describing high performing medical homes for young children.

The programs and practices involved in the Health Equity and Young Children's initiative represent cutting-edge efforts to transform child health practice in the earliest years.

Child First

Child First is a two-generation, home-based, psychotherapeutic intervention that works with very vulnerable young children, prenatal through age 5 years, and their families, most of whom have experienced significant trauma and adversity (including poverty, domestic violence, maternal depression, substance abuse, and homelessness). The goal is to decrease serious mental health concerns in child and parent, child developmental and learning problems, and abuse and neglect. Child First began in Bridgeport, Connecticut in 2001. Teams of mental health clinicians and care coordinators provide home visits that respond holistically to the family, including psychotherapy to foster a responsive, nurturing caregiver-child relationship to heal the effects of trauma and adversity, connection to comprehensive services and supports, and scaffolding of executive functioning skills. Child First has shown strong research results. A randomized clinical trial found statistically significant improvement in young child mental health, language development, and maternal mental health; reduced involvement in child protective services; and connection to comprehensive community services and supports.

Evaluation through six years of replication has continued to show these strong outcomes. Child First is one of the HRSA designated, national, evidence-based Maternal, Infant, and Early Childhood Home Visiting (MIECHV) models. Child First has established a National Program Office to support replication through state affiliates that include a clinical director as well as home visiting teams.

HEYC Convening Participant: Darcy Lowell, Connecticut National Office

The Children's Clinic (TCC)

TCC was founded in 1939 in the greater Long Beach Community in California, to provide access to health care for all children. Particularly since 1990, TCC has expanded to twelve community centers, several in elementary and middle schools, that provide a comprehensive approach to healthy child development throughout the community, with a mission “to provide innovative, integrative, and quality health care that will contribute to a healthy community, focusing on those in need and working with patients and the community as partners in their overall wellbeing.” TCC has reduced disparities in health through offering a medical home that goes well beyond medical care and responds to legal and social concerns and partners with children and their families. TCC's includes a multi-disciplinary team of physicians, nurse practitioners, mental health professionals, medical legal partnership (MLP) and health educators to provide preventive, acute and chronic care for children and adults; prenatal care; care management; behavioral health screenings and counseling; health education and outreach; eligibility screening and enrollment; interpretation and translation; and referrals to community resources. Most recently, TCC implemented the Everychild Bright Beginnings Initiative to screen pregnant mothers and parents of young children for protective factors and exposure to childhood adversity and toxic stress and to provide interventions and referrals for those most at risk. TCC became the first organization in Los Angeles County to be certified by the National Council for Behavior Health as a trauma informed organization.

HEYC Convening Participant: Elisa Nicholson and Jina Lawler, Long Beach, California

Florida Maternal, Infant and Early Childhood Home Visiting Initiative – Early Childhood Comprehensive Services (ECCS)

FL Maternal, Infant and Early Childhood Home Visiting Initiative – ECCS is involved in the development of early childhood system of care to promote developmental screening, linkage to services with a particular focus on building a continuum of care starting at birth (home visiting) through kindergarten entry (early learning & child care).

HEYC Convening Participant: Carol Brady, Florida Site

First 5 San Diego's Healthy Development Services (HDS)

HDS operates through a number of pediatric health care settings and community sites in San Diego County to provide developmental check-ups for children birth-to-five and to follow up, where concerns are identified, through parent coaching, classes, workshops, and therapy. HDS further works with a wide range of community providers and organizations to ensure parents and other caregivers have the help and support to address developmental and behavior child health concerns. HDS has shown individualized gains, after even brief interventions, in either behavioral or development areas of concern for most of the children served. Qualitative findings have shown an increase in parent-child interactions among participants in the program. Moreover, HDS has shown impact in improving the communication and collaboration between practitioners and parents and with community providers. In 2015, HDS received the prestigious designation as a Bright Idea from the Government Innovators Network, a program of the John F. Kennedy School of Government at Harvard University.

HEYC Convening Participant: Lily Valmidiano and Nathan McFarland, AAP-San Diego, California

Healthy Steps for Young Children (Healthy Steps)

Healthy Steps originated in 1996, with partnerships formed with 24 pediatric and family practice sites across the country in 1997. The goal of Healthy Steps was to design and test a new approach to primary care for young children that would focus upon supporting parents in nurturing their child's development. Healthy Steps specialists who were nurses, nurse practitioners, child development specialists, and social workers, were integrated into the primary practice to respond to the family's needs for information and support about their child's healthy development. The 2003 national evaluation of more than 4,500 children served by 15 of the original Healthy Steps sites showed impressive gains in improving family participation in well-child visits, in securing child immunizations, in increasing positive motherchild activities, increasing the sensitivity of parents to their children's cues for attention, and in reducing the use of harsh disciplinary practices – all related to the safety, stability, and nurturing in the home environment recognized as foundational to healthy child development. Through a national resource center, Healthy Steps continues to be replicated and adapted and further evaluated for its impacts. One recent research article on a Healthy Steps site,

Montefiore in New York City, showed very positive impacts by age five not only on parent-child interactions and child social, emotional, and cognitive development, but on body weight and reduction in obesity (bmi>.95)."

HEYC Convening Participant: Anita Krolczyk, Anita Berry, La'Tasha Lee, and Catalina Ariza, Illinois

Maricopa Integrated Health System (MIHS)

MIHS is the only public, non-profit teaching hospital and health care system in Arizona, providing primary and specialty health care in Maricopa County (including Phoenix). Almost all MIHS's patients are low income, and virtually all young children are covered under Medicaid, if they have any health coverage. MIHS operates a care coordination/medical home model which uses trained care coordinators to provide services to children birth through age 5 and their families, employing evidence-based clinical guidelines and measuring progress on improving outcomes for children with developmental delays and asthma and on promoting healthy nutrition and weight. MIHS has demonstrated substantial gains, for individual families served and on a population level, in improving family engagement and healthy child development. Key to its operations is the warm handoff from the practitioner to the care coordinator, depending on the child's or family's need for services, and an individualized care plan developed for all families. MIHS has incorporated, through funding from First Things First, five Family Learning Centers as places that support families in providing safe, stable, and nurturing home environments. Family Learning Centers typically provide weekly classes on parenting skills, child development and nutrition. The centers serve as sources of information about child development and parenting skills, and house other activities for children and their families that promote social connections and healthy activities. MIHS incorporates this work into its graduate medical education (GME) training, with long-term expectations for creating the next generation of primary child health practitioners that integrate such an approach into their own practices.

HEYC Convening Participant: Glenda Ramirez, and Julia Kelly; Maricopa County, Arizona

Medical-Legal Partnership (MLP)

The first MLP program was established in 1993 at Boston City Hospital (now Boston Medical Center), the largest safety net hospital in New England. Its success in responding to patient, family and community health-harming social and legal needs has led to substantial adaptation and expansion, with a National Center for Medical-Legal Partnerships established in 2006 to support this work. MLPs now are present in 292 health care institutions in 36 states. MLPs first were initiated in pediatrics, but now exist in a range of primary care and other medical settings. MLPs embed legal professionals into the health care team to identify and respond to the social and legal issues that jeopardize patient and family health and stability and contribute to stress. MLP legal staff is available to address such issues as evictions and utility shutoffs, difficulties securing SSI and other benefits, legal issues affecting employment, and other justice issues that jeopardize health. In partnership with health care providers, MLP legal staff provide individual advocacy for patients and families as well as engage with the larger community to resolve systemic issues and support policy changes aimed at improving community health. The MLP approach also includes training and support for health professionals to help them identify and address the social determinants of health, with the goal of creating an environment for robust inter-professional collaboration to achieve the best outcomes for patients. In its more than twenty years' experience, MLP has demonstrated its effectiveness in stabilizing families of young children so they can provide a nurturing home, removing environmental risks from the home itself, and supporting young children's engagement in evidence-based programs to improve their health and development.

HEYC Convening Participant: Carrie Chapman; Chicago Site

MYCHILD & PROJECT LAUNCH MA Partnership for Early Childhood Mental Health Integration

The SAMHSA-funded MA Partnership for Early Childhood Mental Health Integration designed and tested a model to address early childhood mental health needs at 7 Boston sites: 5 CHCs, 1 hospital clinic and Boston's Health Care for the Homeless program. Full integration into pediatric primary care settings and deployment of a unique two-person team—an early childhood trained, master's level mental health clinician and a trained “family partner” with lived experience—were key features of the model. Teams were linked to families via a warm hand-off by a pediatrician, based on screening or clinical judgment. Team activities included family case management and support, family, provider and community consultation and education around early childhood mental health needs, and short- and medium-term family-centered, dyadic care for children in need of intervention. Outcomes included reduced maternal stress and depression, improved child social and emotional health and improved provider satisfaction with the process of care. The model is now being replicated in three additional MA cities; an online toolkit offers guidance to other sites interested in replication.

HEYC Convening Participant: Natasha Byars; Boston, Massachusetts

Primary Health Care (PHC)

PHC is a community health center with six primary care sites in Des Moines, Ames, and Marshalltown. Half of PHC's clients, and an even larger share of its young children, are covered under Medicaid; about ten percent are homeless at the time they receive services; and a large share of those with no health coverage are immigrants or refugees. PHC incorporates a team approach within each of its sites that enables primary practitioners to call in either a family support worker or a behavioral health specialist at the time of the office visit to respond to social and mental health concerns. PHC has added substance abuse treatment specialists that rotate around the sites and can be called upon for both consulting and direct patient care. Family support workers, most of whom are bilingual and have roots in the communities they serve, play vital care coordination roles in linking families to culturally and linguistically responsive community resources. These referrals include formal connections with Iowa Legal Aid for specific medical-legal assistance and First Five (a state program modeled after Help Me Grow) for connections to early childhood developmental services. With funding under a HUD grant, PHC has established a housing initiative that works with area homeless and housing programs to secure safe housing, including its own outreach and medical care services to homeless shelters. PHC incorporates within its office visit Medicaid reimbursement structure a share of the costs for its family support and behavioral health staff and has a PMPM arrangement for enhanced care coordination for clients with more complex medical needs. PHC makes use of its footprint within underserved neighborhoods to be a locus not only for providing medical care but for connecting isolated families with sources of culturally and linguistically responsive support.

HEYC Convening Participant: Bery Engebretsen and Heidi Shreck; Des Moines, Iowa

Developmental Understanding and Legal Collaborations for Everyone (Project DULCE)

Project DULCE supports families for the first six months following the birth of a new infant. Based at the infant's primary care medical home, a DULCE family specialist joins the healthcare team and provides additional support on healthy child development and parenting support by helping parents connect to both formal and informal community resources. The DULCE intervention incorporates a protective factors approach and draws on and incorporates components of the Medical-Legal Partnership model to ensure that families have access to the resources they need. Initially established as a research program at Boston Medical Center, Project DULCE improved parental knowledge of child development, better met family needs for concrete services, and successfully engaged and produced substantial gains in parental resiliency for families determined to be at-risk. The Center for the Study of Social Policy (CSSP) and city and county partners are testing the adoption and adaptation of DULCE in five localities within seven clinical settings across the US, including in three California counties (Alameda, Los Angeles and Orange Counties); Palm Beach County, FL, and Lamoille Valley, VT.

HEYC Convening Participant: Patsy Hampton, National Office and Scott Johnson (Vermont Site)

Safe Environment for Every KID (SEEK)

SEEK model was developed through the University of Maryland School of Medicine to help promote children's health, development and safety and to prevent child abuse and neglect. This is done by enhanc-

ing pediatric primary care by identifying and helping address prevalent psychosocial problems such as parental depression. SEEK includes training of health practitioners, routine screening of families during children's checkups, collaboration with a social worker or behavioral health professional, parent handouts and follow-up. Two large randomized, controlled studies—one in an urban clinic serving a very low-income population and one in suburban private practices serving a middle-income population—had very promising findings. The first showed substantial reductions in reported child abuse and neglect; the second showed significantly less use of harsh disciplinary practices and psychological abuse. In both, SEEK practitioners had greater comfort, perceived competence and improved behavior regarding their roles, and this was sustained for up to 36 months. An economic analysis of the cost of SEEK compared with medical costs associated with child abuse revealed substantial cost savings. Much work has been done to help interested clinicians implement SEEK, such as the online SEEK training videos.

HEYC Convening Participant: Howard Dubowitz, University of Maryland

Appendix E. Reimbursing for Office Visits and Screening, including Major Medicaid CPT (Billing) Codes for Preventive Well-Child / EPSDT Visits and Related Screening for Young Children 0 to 5

All states provide reimbursement for well-child office visits and administering selected screening to assess children's health and development. As shown below, there are specific billing codes for providing office, well-child visits for infants (0-1) and toddlers (1-4) [the 993xx series], although states still may use the general billing codes for these visits [the 992xx series].

For both well-child office visits and for screening, states vary in their level of reimbursement to providers under Medicaid. This is a brief summary of two reports—one on primary care visits and one on child screenings—reviewing state responses.

Reimbursing for Physician Office Visits

Since 1993, the Urban Institute has produced periodic reports on Medicaid physician fees for primary care and for selected other services. The latest report, *Medicare Physician Fees After the ACA Primary Care Fee Bump*, March, 2017, included an analysis of states that did and did not continue the increase to Medicare reimbursement rates for primary care provided from 2014 to 2016 under the Affordable Care Act. The findings indicate 19 states continued the increase, in whole or in part.

The paper noted, “Medicaid has historically paid physicians lower fees than either private insurance or Medicare for the same services” and the federal “bump” in payments was in large measure to insure that physicians would take on patients who had become Medicaid eligible, recognizing that low payments had been a barrier to seeing additional Medicaid beneficiaries. This increase was for patients of all ages, although it was clearly included with the recognition that Medicaid expansion would primarily add more low-income adults ages 18-64.

While the Urban Institute limited its review to fee-for-service payments and not those under managed care, the authors noted that these generally were very closely aligned. The Urban Institute also limited its review to the 992xx office visit billing codes, and not the 993xx codes. Again, when states use the 993xx codes, they often are very close in the reimbursement to the respective 992xx codes.

Primary Care Mean, Maximum, and Minimum Medicaid Fees and Standard Deviations for Selected States, 2016

Code	Procedure	Percent of expenditures	Mean fee (\$)	Maximum fee (\$)	Minimum fee (\$)	Coefficient of variation
99203	Office visit, new patient, 30 minutes	2.7	73.08	174.87	29.00	25.42
99204	Office visit, new patient, 45 minutes	2.3	106.60	271.74	45.00	29.04
99213	Office visit, established patient, 15 minutes	25.5	45.45	118.70	20.64	33.62
99214	Office visit, established patient, 25 minutes	9.5	68.63	176.19	27.00	31.92

As the table shows, there is nearly a six-fold variation in the payment for an established patient 15-minute office visit (which represent 64 percent of all office visits of the four types) from the highest state reimbursement amount—\$118.70—to the lowest state reimbursement amount—\$20.64—with the mean reimbursement of \$45.45 being much closer to the lower rate.

For adults, a lower Medicaid payment may not affect overall practice if Medicaid provides only a small share of the population (e.g. if 80 to 90 percent are covered under private insurance or Medicare). For children, however, Medicaid payments play a much greater role in determining what the practice is able to do. Medicaid systems providing reimbursement for such a visit at a \$20 level clearly can expect a lot less to happen, particularly from a preventive and developmental perspective, than those providing reimbursement at a \$120 level. This is particularly true if half of children are covered by Medicaid/CHIP.

The presence of the 93xxx series of billing codes offers states the opportunity to set standards for those office visits (including both what transpires in the physician-patient time and what happens more generally in the overall office visit, as well as preparation for, and follow-up to that visit). The resulting reimbursement rates make it possible for physicians and their practices to conduct a much more fulsome well-child visit that at least approaches the new guidelines and expectations set out in Bright Futures.

States working with exemplary practices to define reimbursement levels can help to spread best practice and capacity of high performing medical homes.

State Payments for Screening

In addition to reimbursement for office visits, states also provide reimbursement for screenings, including screens for child development, social-emotional development, autism, and others (including maternal depression). Some surveillance and screening may be expected as a part of the well-child visit and built into that rate, but states also can provide reimbursement for specific screens under separate billing codes. As with office visits, states vary in both the degree to which they cover screens and the payments they provide for them. A 2016 survey by the National Academy for State Health Policy found that 45 states provided reimbursement for some developmental screening under the 96110 CPT billing code, with payments varying from \$5 to \$61; only five states had reimbursement rates of \$20 or more. When the overall costs of administering, reviewing, and using the screen are considered, many state reimbursements only cover the minimum.

Coding for Preventive Pediatric Care, 2017

Source: Bright Futures and American Academy of Pediatrics.

Generally, practitioners are reimbursed for performing specific services and billing for those services. In some circumstances under managed care arrangements, practitioners may receive per member per month (PMPM) payments or some performance incentives in addition to bills for services, but they generally are paid for specific covered services they provide. They must document what they have done according to the service they provide, and they are paid a set amount for that service, which can be adjusted based upon who provided that service. In Medicaid, there are a number of billing codes that can be used for such covered services, with a number relating specifically to primary and preventive health services. The following descriptions of CPT codes are taken directly and verbatim from the above document of the American Academy of Pediatrics, although the order of the information has been modified.

Preventive Medicine Services: New Patients

Initial comprehensive preventive medicine E/M of an individual includes an age- and gender-appropriate history; physical examination; counseling, anticipatory guidance, or risk factor reduction interventions; and the ordering of laboratory or diagnostic procedures.

A new patient is defined as one who has not received any professional face-to-face services rendered by physicians and other qualified health care professionals who may report E/M services and reported by a specific CPT® code(s) from a physician/other qualified health care professional, or another physician/other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past 3 years.

CPT Codes:

- 99381: Infant
- 99382: 1-4 year-old

Preventive Medicine Services: Established Patients

Periodic comprehensive preventive medicine reevaluation and management of an individual includes an age- and gender-appropriate history; physical examination; counseling, anticipatory guidance, or risk factor reduction interventions; and the ordering of laboratory or diagnostic procedures.

CPT Codes:

- 99391: Infant
- 99392: 1-4 year-old

Health Risk Assessments

Used to report administration of standardized health risk assessment instruments on the patient or a primary caregiver (e.g. parent) on behalf of the patient.

CPT Codes:

- 96160: Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument
- 96161: Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument

Developmental Screening and Emotional/Behavioral Assessment

Used to report administration of standardized developmental screening instruments or social/emotional assessments. Often reported when performed in the context of preventive medicine services but may also be reported when screening or assessment is performed with other E/M services (e.g., acute illness or follow-up office visits).

Clinical staff (e.g., registered nurse) typically administers and scores the completed instrument, while the physician incorporates the interpretation component into the accompanying E/M service. When a standardized screening or assessment is administered along with any E/M service (e.g., preventive medicine service), both services should be reported, and modifier (significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) may need to be appended to the E/M code to show the E/M service was distinct and necessary at the same visit.

CPT Codes:

- 96110: Developmental screening, per instrument, scoring and documentation
- 96127: Brief emotional/behavioral assessment (e.g., depression inventory) with scoring and documentation, per standardized instrument

Examples of both 96110 and 96127 instruments can be found online at https://www.aap.org/en-us/Documents/coding_preventive_care.pdf

Healthcare Common Procedure Coding System Codes

The HCPCS Level II codes are procedure codes used to report services and supplies not included in the CPT nomenclature. Like CPT codes, HCPCS Level II codes are part of the standard procedure code set under the Health Insurance Portability and Accountability Act of 1996.

Certain payers may require that HCPCS codes be reported in lieu of or as a supplement to CPT codes. The HCPCS nomenclature contains many codes for reporting nonphysician provider patient education, which can be an integral service in the provision of pediatric preventive care.

Examples of HCPCS Level II codes relevant to pediatric preventive care include

- S0302: Completed Early and Periodic Screening, Diagnosis, and Treatment service (List in addition to code for appropriate E/M service.)

Counseling, Risk Factor Reduction, and Behavior Change Intervention Codes

Used to report services provided for the purpose of promoting health and preventing illness or injury.

They are distinct from other E/M services that may be reported separately when performed. However, one exception is you cannot report counseling codes (99401–99404) in addition to preventive medicine service codes (99381–99385 and 99391–99395).

Counseling will vary with age and address such issues as family dynamics, diet and exercise, sexual practices, injury prevention, dental health, and diagnostic or laboratory test results available at the time of the encounter.

Codes are time-based, where the appropriate code is selected according to the approximate time spent providing the service. Codes may be reported when the midpoint for that time has passed. For example, once 8 minutes are documented, one may report 99401.

Extent of counseling or risk factor reduction intervention must be documented in the patient chart to qualify the service based on time.

Counseling or interventions are used for persons without a specific illness for which the counseling might otherwise be used as part of treatment. Cannot be reported with patients who have symptoms or established illness.

For counseling individual patients with symptoms or established illness, report an office or other outpatient service code (99201–99215) instead. For counseling groups of patients with symptoms or established illness, report 99078 (physician educational services rendered to patients in a group setting) instead.

CPT Codes

Preventive Medicine, Individual Counseling

- 99401: Preventive medicine counseling or risk factor reduction intervention(s) provided to an individual; approximately 15 minutes
- 99402: approximately 30 minutes
- 99403: approximately 45 minutes
- 99404: approximately 60 minutes

Preventive Medicine, Group Counseling

- 99411: Preventive medicine counseling or risk factor reduction intervention(s) provided to individuals in a group setting; approximately 30 minutes
- 99412: approximately 60 minutes



505 5th Avenue, Suite 404 / Des Moines, IA 50309 / (515) 280-9027
www.cfpciowa.org